SECTION I: GENERAL INFORMATION

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1 OVERVIEW OF THE UTAH MEDICAID PROGRAM

The Utah Medicaid Program pays medical bills for people who have low incomes or cannot afford the cost of health care and who are found eligible for the program. The Utah Medicaid program is administered by the Utah Department of Health, Division of Health Care Financing. Benefits are paid with federal and state funds.

1 - 1 Applying for Medicaid

Persons seeking assistance to pay for medical services may apply at the Department of Health offices or Medicaid outreach offices in most major hospitals and many area public health clinics. Department of Health offices are located at Department of Workforce Services buildings in some communities. People may call the Medicaid Information Line to find out the location of the nearest office. Refer to Chapter 12, Medicaid Information. People who want to apply for multiple services, such as medical and financial assistance, food stamps, or child care, should apply at the local Department of Workforce Services office.

Individuals with Special Needs (transportation, language)
Persons who need assistance with Medicaid applications due to transportation or language barriers may call Medicaid Information for more information. The Division of Health Care Financing, Bureau of Eligibility Services accepts Medicaid applications by telephone or mail when a person cannot travel to a site where applications are usually processed, such as an Office of Family Support or an outreach site in a clinic or hospital. Medicaid may provide interpretive services for a person who wants to apply for a federal or state medical assistance program. Refer to Chapter 12, Medicaid Information, for phone numbers and hours.

Information Brochure
An information brochure titled “Exploring Medicaid” is available to explain the Medicaid program. The brochure explains rights and responsibilities, the selection of a health care provider, and health care services covered by Medicaid. A copy of the brochure may be obtained by calling Medicaid Information (Refer to Chapter 12) or by contacting any local office of either the Bureau of Eligibility Services (Division of Health Care Financing, Utah Department of Health) or the Utah Department of Workforce Services.

Eligibility Determination
A Medicaid eligibility worker employed by the state agency determines eligibility and issues written notice of the determination. Clients who disagree with the determination may contact the local office supervisor for a conference, call the *Constituent Services Representative for Medicaid, or file for a Fair Hearing.

* The Constituent Services Representative for the Utah Department of Health may be reached through Medicaid Information. Refer to Chapter 12, Medicaid Information.

1 - 2 Medicaid Program Requirements

To be eligible for Medicaid, an applicant must first qualify for a category of Medicaid established by federal regulations. Each category has requirements concerning citizenship, resources (assets), and monthly income. Medicaid eligibility is redetermined each month for each individual.

A brief summary of Medicaid requirements is given in the subsections which follow.

Categories of Medicaid

Each person applying for Medicaid must qualify under one of the following categories:

- Age 65 or older
- Legally disabled or blind
- Pregnant woman
- Child under age 18
- Parent or caretaker of a child under age 19
- Woman with breast or cervical cancer

A person who does not qualify for a category of Medicaid is considered for the Primary Care Network (PCN) Program. Refer to Chapter 13 - 10, Primary Care Network Program.

Citizenship

Full Medicaid benefits are available only to U.S. citizens and legal residents. A person who is not a citizen or a legal resident may qualify for Emergency Services Program. This program limits benefits to emergency medical services only. Refer to Chapter 13 - 8, Emergency Services Program For Non-Citizens.

Resources

Federal regulations limit an individual's resources to $2,000. For a family, the limit starts at $3,000. There are exceptions to the resource limit for a pregnant woman and for a person whose spouse is a resident of a nursing home.

Income

Federal regulations require the state to set monthly income standards which vary based on the category of Medicaid. The income standards are usually associated to the annual Federal Poverty Level (FPL) for the household size. (The FPL is available on the Internet at http://aspe.hhs.gov/poverty/poverty.htm.) Here are examples of the income standards:

Category of Medicaid	Income as Percent of FPL
Age 65 or older	100%
Blind	54% to 75%
Legally disabled	100%
Pregnant woman	133%
Child through age 18	100%
Parent or caretaker relative of a child	54% to 60%
Woman with breast or cervical cancer	250%

The Federal Poverty Level is available on the Internet at http://aspe.hhs.gov/poverty/poverty.htm

Medicaid Medically Needy Program (Spenddown)

An applicant who has monthly income which is more than the monthly income standard, but less than the amount needed to pay his or her medical bills, may be considered for the Medicaid Medically Needy program. The program is also referred to as the "spenddown" program. To qualify for Medicaid coverage of medical bills, the person agrees to "spend down" his or her monthly income to the Medicaid income standard. The person may choose to either pay "excess" monthly income to the state or to pay a portion of his or her monthly medical bills directly to the medical provider. A provider is notified of the patient's agreement to pay a portion of medical bills with Form MEEU. Refer to Chapter 6 - 8, Exceptions to Prohibition on Billing Patients, item 2, Form MEEU attached to Medicaid Identification Card.

Third Party Liability

The Medicaid client must identify any liable third party who may be responsible for payment of medical services rendered to the client. A liable third party includes any person or entity such as health insurance, a health maintenance organization, or Medicare.

1 - 3 Retroactive Medicaid

The Medicaid eligibility worker may approve Medicaid coverage for a client prior to the first of the month in which the client applied for Medicaid. The eligibility period prior to the month of application is called the retroactive period. Effective August 1, 2001, the retroactive coverage period for Medicaid is limited to a three month time period immediately preceding the date of application. Coverage may begin on the calendar day which matches the day of the month in which the application was filed. For example, a client applies on May 16 for Medicaid and asks for retroactive coverage for services in February. Retroactive Medicaid may be approved back to February 16. Services prior to that date would not be covered.

If approved for retroactive Medicaid coverage, the client receives a Medicaid Identification Card for each eligible month. A patient who received medical, dental or mental health services and subsequently qualifies for Medicaid may return to each provider with a Medicaid Identification Card for the month in which service was provided. A provider who has already rendered services may subsequently choose to accept Medicaid as payment in full or refuse to seek Medicaid payment because the patient had not been determined eligible for Medicaid at the time of service.

Note: A Medicaid client may be retroactively enrolled in a Prepaid Mental Health Plan. A Medicaid client cannot retroactively enroll in a health maintenance organization nor retroactively select a Primary Care Provider through Medicaid.

1 - 4 Choice of Health Care Provider

Once an applicant is determined eligible for Medicaid, he or she must select a health care provider. Along the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties), the client must enroll in a managed care plan, also called a health maintenance organization (HMO). In other areas of Utah, Medicaid clients may select a Primary Care Provider who accepts Medicaid, or an HMO if one is available.

1 - 5 Restriction Program

Medicaid clients who inappropriately utilize health care services may be referred to and enrolled in the Medicaid Restriction Program. This program provides safeguards against inappropriate and excessive use of Medicaid services. Clients are identified for enrollment through:

l. Quarterly review of patient profiles to identify exceptional utilization of medical services.

2. Verbal and written reports of inappropriate use of services generated by one or more health care providers. These reports are verified through a review of the patient's claim history by Medicaid staff and medical consultants.

3. Referral from Medicaid staff.

Clients selected for enrollment in the Restriction Program are informed of the reasons, counseled in the appropriate use of health care services, and assisted in selecting a Primary Care Provider or managed care plan and to a particular pharmacy. Clients are issued a Restriction Medicaid Identification Card. These clients must receive all health care services through either the assigned provider or HMO, or receive a referral from those providers, and all pharmacy services from the assigned pharmacy. Medicaid will only pay claims for services rendered by the providers listed on the card and by providers to whom the client has been appropriately referred. However, emergency services are not restricted to these providers.

Verification
An example of the Restriction Medicaid Identification Card is included with the examples of cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

1 - 6 Woman with Breast or Cervical Cancer

The Breast and Cervical Cancer Prevention and Treatment Act allows states to provide full Medicaid benefits to a qualified woman in need of treatment for breast and cervical cancers, including precancerous conditions and early stage cancer. The Utah Cancer Control Program (UCCP) will refer the woman for Medicaid coverage.

The woman must meet all of the following requirements:

1. Diagnosis after April 1st, 2001, by ANY health care provider in Utah, of breast or cervical cancer which requires treatment, including precancerous conditions.
2. Under the age of 65.
3. No insurance to cover the treatment needed.
4. A U.S. citizen or qualified alien.
5. Income is at or below 250% of the Federal Poverty Level (The FPL is available on the Internet at http://aspe.hhs.gov/poverty/poverty.htm.

For more information, call the Utah Department of Health, Utah Cancer Control Program: (801) 538-6990 or (801) 538-6491. Please have the patient's complete name and telephone number(s).

1 - 7 Program Monitoring

The State is responsible for monitoring all medical assistance programs, including Medicaid, with respect to medical need, extent and appropriateness of care, and program effectiveness. Monitoring includes audit procedures, on-site reviews, quality assurance and utilization reviews.

2 COVERED SERVICES

Services available under the Medicaid State Plan are listed in Chapter 2 - 1, Medicaid Services. Services are reimbursed either directly by Medicaid or by a managed care plan with which Medicaid contracts to provide the covered services. When the Medicaid patient has a Primary Care Provider, this provider must provide an appropriate referral before Medicaid will pay for medical services received from any other provider.

Covered services are generally limited by federal guidelines as set forth under Title XIX of the federal Social Security Act, Title 42 of the Code of Federal Regulations (CFR), and the Utah Administrative Code, Rule R414-1-5, Services Available. SECTION 2, Scope of Service, has conditions of coverage for specific types of services.

2 - 1 Medicaid Services

Covered services include:

1. Hospital Services:
   A. Inpatient hospital services with the exception of those services provided in an institution for mental disease.
   B. Outpatient hospital services
   C. Outpatient surgical centers
   D. Free-standing birth centers

2. Rural health clinic services.

3. Laboratory and x-ray services.

4. Skilled nursing facility services, other than services in an institution for mental diseases, for individuals 21 years of age or older.

5. CHEC Services: Early and periodic screening and diagnoses of individuals less than 21 years of age and treatment of conditions found are provided in accordance with Federal requirements for the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program. In Utah, this program is called the **C**hild **H**ealth **E**valuation and **C**are (CHEC) Program. *Children under age 21 with a current Medicaid Card are automatically enrolled in CHEC.*

   There are three major components to CHEC: Preventive Health Care, Outreach and Education, and Expanded Services.

   A. Preventive Health Care

      A CHEC screening is a **well-child exam** which includes the following:

      ✓ Complete health and developmental history
      ✓ Comprehensive unclothed physical examination, including vision and hearing screening
      ✓ Appropriate immunizations
      ✓ Appropriate laboratory tests
      ✓ Health education

      Children may also receive preventive dental care.

      The CHEC screening is described in SECTION 2, CHEC SERVICES. This section contains recommended protocols and a periodicity schedule based on American Academy of Pediatrics recommendations.

B. Outreach and Education

When children are newly eligible for Medicaid or due for a periodic exam, the family receives a letter and a phone call about the importance of preventive health care and the availability of screening services. Families are offered assistance in scheduling an appointment and transportation, if needed. The Department of Health contracts with local Health Departments for outreach and education.

C. Expanded Services

Medicaid recipients under age 21 may receive **medically necessary** services that are not available to adults. The definition of medical necessity may be less restrictive for children. However, a written prior authorization request must be submitted to document the medical necessity of the CHEC services. Refer to Chapter 9, Prior Authorization, for more information.

6. Family planning services and supplies for individuals of childbearing age.

7. Physician's services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

8. Podiatric services.

9. Optometry services.

10. Psychology services for individuals under age 21.

11. Home health services including intermittent or part-time nursing services provided by a home health agency, home health aide services, and medical supplies, equipment, and appliances suitable for use in the home.

12. Private duty nursing services for children under age 21.

13. Clinic services.

14. Dental services.

15. Physical therapy, occupational therapy and related services.

16. Services for individuals with speech, hearing, and language disorders furnished by or under the supervision of a speech pathologist or audiologist.

17. Prescribed drugs, dentures, and prosthetic devices, and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

18. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the State Plan.

19. Services for individuals age 65 or older in institutions for mental diseases:

20. Inpatient hospital services for individuals age 65 or older in institutions for mental diseases.

21. Skilled nursing services for individuals age 65 or older in institutions for mental diseases.

22. Intermediate care facility services for individuals age 65 or older in institutions for mental diseases.

23. Intermediate care facility services, other than such services in an institution for mental diseases, for persons determined, in accordance with section 1902(a)(31)(A) of the Social Security Act, to be in need of such care, including those furnished in a public institution or a distinct part thereof for the mentally retarded or persons with related conditions.

24. Inpatient psychiatric facility services for individuals less than 22 years of age.

25. Nurse-midwife services and free-standing birth centers.

26. Hospice care in accordance with section 1905(o) of the Social Security Act.

27. Case management services in accordance with section 1905(a)(19) or section 1915(g) of the Social Security Act, as to the group or groups.

28. Enhanced services for pregnant women in addition to services for uncomplicated maternity cases and Certified Nurse Midwife services. Enhanced services include:

    A. Perinatal care coordination (case management)

    B. Prenatal and postnatal home visits

    C. Group Prenatal and postnatal education

    D. Nutritional assessment and counseling

    E. Prenatal and postnatal psychosocial counseling

30. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider in accordance with section 1920 of the Social Security Act.

31. Extended services to pregnant women including pregnancy-related and postpartum services for 60 days after the pregnancy ends, including additional services for any other medical conditions that may complicate pregnancy with increases of service.

32. Other medical care and other types of remedial care recognized under State law, specified by the Secretary of the United States Department of Health and Human Services, pursuant to 42 CFR §440.60 and 42 CFR §440.170, include:

    A. Medical or remedial care or services, provided by licensed practitioners, other than physician's services, within the scope of practice as defined by state law;

    B. Medical transportation;

    C. Skilled nursing facility services for patients less than 21 years of age;

    D. Emergency hospital services; and

    E. Personal care services in the patient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under the supervision of a registered nurse.

33. Medical interpretive services for clients with limited English proficiency or disabilities. Refer to Chapter 6 - 12, Medical Interpretive Services.

34. Third party insurance premiums, including the Medicare Part A and/or Part B payments. Payments for Medicare clients are covered under the Buy-in Program. Other third party health care premium(s) may be covered under the Buy-Out Program if continued third party coverage for the eligible recipient is determined to be cost-effective.

2 - 2 Limiting Amount, Duration or Scope of Services

The Division of Health Care Financing has the authority to limit the amount, duration, or scope of services or to exclude a service or procedure from coverage by Medicaid. Policy recommendations are based on medical necessity, appropriateness, and utilization control concerns (42 CFR §440.230). Recommendations consider the following:

- Existing policy for non-covered cosmetic, experimental or nonproven medical practices.
- Information available from the Special Coverage Issues Bureau, Centers for Medicare & Medicaid Services, Department of Health and Human Services.
- Information and recommendations from physician consultants employed by the Utah Department of Health, Division of Health Care Financing.
- Consultation with appropriate groups or individuals from various professional organizations.
- Legal counsel.
- Consultation with policy staff of the local Medicare carrier.
- Consultation with policy staff of Medicaid programs in other states (selected).
- Other sources determined appropriate by the specific issue being addressed.

2 - 3 Out-of-State Services

Medical services are furnished out-of-state to Utah Medicaid clients, in accordance with 42 CFR §431.52. The same services available within the state are available out-of-state from any provider who is or will be enrolled with Utah's Medicaid program.

2 - 4 Group Health Insurance and Medicaid: Certificate of Coverage

Medicaid recipients, current and previous, may benefit from the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The law offers more protections for working people who move from one group health insurance plan to another or who have been covered by any health plan, including Medicaid or Medicare, just prior to enrolling in a group health plan. The law is especially helpful for people who have a pre-existing medical condition and want to enroll in an insurance plan.

HIPAA stipulates that when a person changes from one health plan to another, the length of time the person has had recent, continuous group health coverage must be considered as 'credit' toward the exclusion for a pre-existing condition. This credit may allow the client to reduce or eliminate the months he or she would otherwise have to wait for medical treatment of a pre-existing condition under the health plan. (HIPAA defines a pre-existing condition as a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date in any new health plan.) The months a client was eligible for Medicaid coverage count as credit.

The group health insurer will need proof of the months the client was eligible for Medicaid. Acceptable proof includes a Certificate of Coverage from the Department of Health. The certificate verifies the client had Medicaid eligibility which can be used as credit toward any pre-existing condition exclusion.

Client Information or Questions
Medicaid clients who want more information about the Certificate of Coverage or want to request a certificate for himself and family members may call Medicaid Information. (Refer to Chapter 12, Medicaid Information.) The caller will be transferred.

Conditions of Coverage
The Department of Health determines whether the client's coverage under Medicaid qualifies under the provisions of the law. If so, a Certificate of Coverage is created and sent to the client's home. To qualify, coverage must have been recent and continuous. If the client has a lapse in coverage for more than two months in a row, the prior period of coverage will not be counted. However, the client may have received coverage under more than one plan, and as long as there were no gaps in his or her coverage, months of prior coverage do count.

For example, if the client was covered by a health plan or Medicaid in January, February, and March, and then enrolled in another health plan in April, the client could use the three months of coverage (January - March) to reduce the exclusion period by three months. If the exclusion period was six months, the client would only have a three-month exclusion period.

2 - 5 Inmates Not Entitled to Medicaid Services

When a Medicaid client is an "inmate of a public institution" (including jail), Medicaid services are not a benefit even though the client has a Medicaid card. The penal facility is responsible for all medical expenses incurred during the client's stay including medical treatment, medical supplies and prescriptions. It is not appropriate for a third party to use the Medicaid card to pick up medications/supplies for someone that is in jail and deliver them to the inmate. Medicaid may recover funds paid under these circumstances. References: 42 CFR 435.1008 and 1009

3 FEE-FOR-SERVICE MEDICAID

Fee-for-Service means services covered directly by Medicaid and not by a managed care plan. A fee-for-service Medicaid client is defined as either of the following:

1. The client is not enrolled in a managed care plan, such as a health maintenance organization (HMO); or

2. The client is enrolled in a managed care plan, but the service that is needed is covered by Medicaid, not by the plan. Services not included in the Medicaid contract with an individual managed care plan are referred to as 'carve-out' services.

Medicaid clients who are not enrolled in a managed care plan will not have an HMO or a Prepaid Mental Health plan on their Medicaid Identification Card. These clients may receive services from any provider who accepts Medicaid. When the client is enrolled in an HMO plan that does not cover pharmacy and/or dental services, the Medicaid Identification Card states "a participating pharmacy" under Pharmacy and "a participating dentist" under Dental. In either case, any Medicaid pharmacy /dental provider may render services to that client.

Medicaid Provider Manuals and Information Bulletins
Fee-for-service providers must follow the scope of service, policies, procedures and processes in the Utah Medicaid Program Provider Manual and Medicaid Information Bulletins.

Services covered by Medicaid, instead of the managed care plan, vary according to the individual contracts with managed care plans. For example, some HMO contracts do not include pharmacy and/or dental services. Medicaid refers to services not covered in a contract with an HMO or Prepaid Mental Health Plan as 'carve-out' services.

Fee-For-Service Clients
Fee-for-service clients may receive covered services from any Medicaid provider. The provider must follow Medicaid coverage and prior authorization requirements. The provider submits the claim to and obtains payment from Medicaid. All questions concerning services covered by Medicaid **and not** by the managed care plan should be directed to Medicaid Information. (Refer to Chapter 12, Medicaid Information.) For example, a Medicaid client enrolled in an HMO which does NOT cover pharmacy services may receive pharmacy services from any Medicaid pharmacy provider.

Medicaid will not pay for services covered by a plan in which the Medicaid recipient is enrolled. Medicaid will deny payment on a fee for service claim when the service is covered under a managed care plan. Because information as to what plans the recipient must use is available to providers on the Medicaid Card, electronically through *ACCESSNOW* and *Medicaid On-Line*, or by contacting Medicaid Information, a fee for service claim will not be paid even when information was given in error by Medicaid agency staff.

When the Medicaid patient has a Primary Care Provider, this provider must provide an appropriate referral before Medicaid will pay for medical services received from any other provider. Refer to Chapter 6 - 9, Physician Referrals.

4 MANAGED CARE PLANS

Medicaid contracts with health care organizations to provide managed health care to Medicaid recipients in Salt Lake, Utah, Davis and Weber counties. Plans may include a health maintenance organization (HMO) and a Prepaid Mental Health Plan (PMHP). Medicaid typically pays a monthly fee for each Medicaid recipient enrolled in the plan, and the plan is responsible for all health care services specified in the contract. The plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits described in Chapter 2, Covered Services. Each plan specifies services which are covered, those which require prior authorization or a referral, and the conditions for authorization. Each plan also specifies the process to request authorization for services to be provided for Medicaid patients enrolled in that plan. Services not included in the Medicaid contract with an individual managed care plan are referred to as 'carve-out' services.

Client Enrollment in Managed Care Plan
The Division of Health Care Financing requires all Medicaid clients in Weber, Davis, Salt Lake, and Utah counties to enroll in Health Maintenance Organizations (HMOs). Medicaid will not pay for services covered by a plan in which the Medicaid recipient is enrolled. Medicaid will deny payment on a fee for service claim when the service is covered under a managed care plan. Because information as to what plans the recipient must use is available to providers on the Medicaid Card, electronically through ACCESSNOW and Medicaid On-Line, or by contacting Medicaid Information, a fee-for-service claim will not be paid even when information was given in error by Medicaid agency staff.

The Utah Medicaid Identification Card states the name of each managed care plan in which the recipient is enrolled. Medicaid clients who are *not* enrolled in a managed care plan and *not* in the Restriction Program may receive services from any provider who accepts Medicaid. Refer to Chapter 5, Verifying Medicaid Eligibility, for information about how to verify a patient's enrollment in a plan. Refer to Chapter 1 - 5, Restriction Program, for information about this program.

Provider Enrollment in Managed Care Plan
Providers must be affiliated with the managed health care plan and follow its coverage and authorization requirements. The provider obtains payment from the health care plan. All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. A list of the Medicaid HMOs and PMHPs, including telephone numbers, is included in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Medicaid Provider Manuals and Information Bulletins
Medicaid providers enrolled as a managed care plan provider and providing services to a plan enrollee must follow the requirements of that plan. The Utah Medicaid Program Provider Manual and Medicaid Information Bulletins are intended for fee-for-service providers, not for managed care plan providers.

Services covered by Medicaid, instead of the managed care plan, vary according to the individual contracts with managed care plans. Medicaid refers to services not covered in a contract with an HMO or Prepaid Mental Health Plan as 'carve-out' services.

4 - 1 Health Maintenance Organizations

When a person applying for Medicaid is determined eligible, he or she must select a health care provider. A Health Program Representative in the Medicaid office explains the health care choices, including mandatory enrollment in an HMO, and the exemption policy for clients whose health care needs cannot be adequately met by an HMO. The HMO is responsible for all services as set forth under Title XIX of the federal Social Security Act, Title 42 of the Code of Federal Regulations (CFR), and the Utah Administrative Code, Rule R414-1-5, Services Available.

4 - 2 Mental Health Services

In most areas of the state, Medicaid covers outpatient and inpatient mental health services ONLY when provided through a Prepaid Mental Health Plan. Medicaid clients who live in certain counties of the state **must receive all** mental health services from community mental health centers which have contracted with the Medicaid agency as a Prepaid Mental Health Plan (PMHP).

Physicians or psychologists treating individuals who **may become eligible for Medicaid** should contact the appropriate Prepaid Mental Health Plan to ensure payment or arrange for the patient to be transferred to the contracting mental health center for continued services. Even if the individual is not yet enrolled with a PMHP, he or she may be entitled to retroactive Medicaid eligibility. (See Chapter 1 - 3, Retroactive Medicaid), and the PMHP contractor will be responsible for services. A list of Prepaid Mental Health Plans by county and telephone numbers is provided in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

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4 - 3 Other Managed Care Plans

Effective for dates of service on or after September 1, 1997, chiropractic providers must contact the Chiropractic Health Plan (CHP) directly for details of provider participation, claim submission, payments and requests for prior authorization. All chiropractic services are covered by a capitated reimbursement contract with CHP.

4 - 4 Managed Care Plans and Prior Authorization

Each managed care plan specifies which services require prior authorization (PA) and the conditions for authorization. When a provider contacts Medicaid to request PA for services to a patient covered by a managed care plan, Medicaid must refer the provider to that plan. Medicaid cannot authorize PA requests for services for patients enrolled in managed care plans, unless the services are not included under the Medicaid contract with the plan.

Because information as to what plan the client must use is available to providers, the provider must follow the plan's procedures for authorization in order to receive reimbursement. When the client is enrolled in a managed care plan, and Medicaid staff prior authorize a service in error, instead of referring the provider to the client's plan, Medicaid cannot pay for the service. If the provider fails to follow the plan's procedures for authorization, the managed care plan may also refuse to pay for the service.

4 - 5 Exemption from Mandatory HMO Enrollment

A Medicaid client may request an exemption from mandatory HMO enrollment by submitting a request to the Division of Health Care Financing HMO Exemption Committee through a Health Program Representative. The request must include documentation showing: (1) the existence or development of a condition which requires critical care from a specialist or a group of specialists not affiliated with any of the HMOs; and (2) the HMO has offered no reasonable alternatives.

Before the request is considered by the HMO Exemption Committee, the Health Program Representative will work with the client to find alternatives to exemption.

1. If a client is currently enrolled in an HMO, the client and Health Program Representative will attempt to resolve the request through negotiation with the HMO or transfer to another HMO. If a satisfactory solution is not achieved, the request will go to the HMO Exemption Committee for review. A decision will be made within 15 calendar days.

2. If the client is not yet enrolled in an HMO, the Health Program Representative may delay HMO enrollment for 60 days. During this time, the client and HMO either work out a satisfactory solution, or the request will go to the HMO Exemption Committee for review and a decision.

The HMO Exemption Committee may approve the request if there is a reasonable expectation that the client's health would suffer without an HMO exemption. The Committee may grant temporary exemptions for up to one year based on the client's individual circumstances.

When a client is granted an HMO exemption, he or she must select a Primary Care Physician to receive services on a fee-for-service basis.

As a Medicaid provider, you may be asked by a client who is requesting an exemption to furnish information concerning his or her medical condition. If you need additional information to help you respond to the client's request, or want a complete copy of the HMO Exemption policy and process, call Medicaid Information (Refer to Chapter 12, Medicaid Information) and ask for the HMO Quality Assurance Coordinator.

4 - 6 Emergency Services for Clients in a Managed Care Plan

Managed care plans, both HMOs and Prepaid Mental Health Plans, are responsible for covering all emergency services for enrollees, regardless of where the emergency occurred and was treated. An emergency is any covered service immediately required, due to an unforeseen illness or condition, to avoid endangering the individual or others if immediate treatment were to be postponed. Federal regulations [42 CFR §447.53(b)(4)] state emergency services are services provided in a hospital, clinic, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that the absence of immediate medical attention could reasonably be expected to result in one of these three conditions:

1. Placing the patient's health in serious jeopardy;

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Providers who render emergency care to a patient enrolled in a managed care plan must obtain approval from the plan within the time frame specified by the plan, which is usually within 24 hours of service. The provider will be reimbursed only when the provider has made a good faith effort to obtain approval from the plan within the time frame specified.

The emergency room facility charge is not covered under the Prepaid Mental Health Plan and should be billed to Medicaid as a fee-for-service billing.

4 - 7 Complaints and Grievances

Complaints and grievances concerning an HMO from either a client or a provider must first go through the HMO's complaint process. If the individual who initiated the complaint is not satisfied with the HMO's final decision, he or she may then contact the Division of Health Care Financing and request a hearing.

4 - 8 Changing HMOs

Medicaid has client advocates called Health Program Representatives (HPRs) who try to help with any type of problem with a managed care plan or HMO. Medicaid clients who are experiencing any problems with their HMO have the right to change to a different HMO.

A client who wants to change the HMO selection should contact his or her Health Program Representative (HPR). The HPR is located in the office where the client was determined eligible for Medicaid. A client can call Medicaid Information and get the telephone number for the HPR. Refer to Chapter 12, Medicaid Information.

5 VERIFYING MEDICAID ELIGIBILITY

A Medicaid client is required to present the Medicaid Identification Card before each service, and every provider must verify each patient's eligibility EACH TIME and BEFORE services are rendered. Providers must know if the client is currently eligible for Medicaid, enrolled in a managed care plan, Emergency Services or the Restriction Program; assigned to a Primary Care Provider; covered by a third party; or responsible for a co-payment or co-insurance. Eligibility and HMO enrollment may change from month to month. The information needed is printed on the client's Medicaid Identification Card or the Interim Verification of Eligibility (Form 695). The provider may wish to copy the card to substantiate the Medicaid claim.

Information is also available through **electronic eligibility inquiry and response (270/271 ANSI X12N Version 4010)**, **ACCESSNOW** and **Medicaid Information**. (Refer to Chapter 12, Medicaid Information.) Explanation of the information required for Medicaid and how to access that information is given in the sub-chapters which follow.

NOTE 1: Medicaid staff make every effort to provide complete and accurate information on all inquiries. However, federal regulations do not allow a claim will not be paid even if the information given to a provider by Medicaid staff was incorrect.

NOTE 2: Temporary Proof of Eligibility
When a temporary proof of eligibility expires, Medicaid will no longer pay claims, unless the client has since been issued a Medicaid Identification Card for the month of service. Two temporary proofs of eligibility are the Baby Your Baby Card and the Interim Verification of Eligibility (Form 695).

- When a client's Medicaid Identification number ends with the letter 'V', the client is eligible ONLY for the Baby Your Baby Program. ALWAYS require the Baby Your Baby Card and check the dates of eligibility. Refer to Chapter 13 - 1, Presumptive Eligibility Program (Baby Your Baby).
- When a client's Medicaid Identification number ends with the letter 'X', the client has an Interim Verification of Eligibility (Form 695). Refer to Chapter 5 - 2, Interim Verification of Medicaid Eligibility (Form 695).

5 - 1 Medicaid Identification Card

Each family or individual eligible for Medicaid receives a Medicaid Identification Card each month. The card is typically received on the first of the month. It lists the following information:

- the month of eligibility
- any limitation of benefits, such as Emergency Services Only
- the name of each eligible individual
- the individual's ten digit Medicaid Identification number
- the individual's sex, date of birth and age
- enrollment in a managed care plan or selection of a Primary Care Provider
- co-payment or co-insurance owed, if any
- the designated Prepaid Mental Health Plan
- the designated dental provider
- the designated pharmacy provider and
- third party liability coverage

Examples of Medicaid Identification Cards and verifications for other medical assistance programs administered by the Department of Health are included in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

5 - 2 Interim Verification of Medicaid Eligibility (Form 695)

Instead of a Medicaid Card, a patient may have an "Interim Verification of Medical Eligibility" (Form 695). This temporary proof of eligibility should contain the same information as the Medicaid Card, except that it will have an expiration date. The Medicaid eligibility worker issues the Interim Verification form when a client needs proof of eligibility and does not yet have the Medicaid Card. If the client has never been assigned a Medicaid Identification Number, the number on the Form 695 is nine digits followed by the letter **X**. As soon as the client has been assigned a 10-digit Medicaid Identification Number, providers must use the permanent identification number to bill for services, rather than the temporary number ending with the letter X.

When a temporary proof of eligibility expires, Medicaid will no longer pay claims, unless the client has since been issued a Medicaid Identification Card for the month of service.

5 - 3 Medicaid Information System: ACCESSNOW

ACCESSNOW, a touch tone telephone eligibility line, is available to providers at no cost. For information on **ACCESSNOW**, refer to Chapter 12, Medicaid Information.

5 - 4 Pharmacy Point of Sale System

The Point of Sale (POS) system provides pharmacists with the capability to submit pharmacy claims electronically. It allows pharmacies to immediately determine Medicaid client eligibility, verify drug coverage, and have "real time" claims processing. For information about the Point of Sale system, refer to SECTION 2, PHARMACY SERVICES.

5 - 5 Third Party Liability (TPL)

The Medicaid Card lists any third party liable for any type of health care services for the patient. If a patient has Third Party Liability (TPL), the name, policy number and group number are listed on the Medicaid Card below the patient's name. Note that some members of a family may have third party coverage, while others have no coverage or different coverage.

If TPL information is incorrect, advise the patient to call the TPL unit in the Office of Recovery Services at the Department of Human Services. This information is printed on the bottom of the Medicaid Card. Providers may also call the TPL unit about incorrect information. TPL information is corrected by the Office of Recovery Services:

In the Salt Lake area, call **536-8798**
The toll-free number in Utah is **1-800-821-2237**
Outside Utah, the toll-free number is **1-800-257-9156**

The provider must explore payment from all other liable parties such as insurance coverage, including an HMO, before seeking Medicaid payment. Refer to Chapter 11 - 4, Billing Third Parties, for information on billing the TPL.

5 - 6 Ancillary Providers

Providers who accept a patient covered by Medicaid are asked to ensure that any ancillary services provided to the patient are delivered by a participating Medicaid provider. This includes lab, x-ray, and anesthesiology services. Please give **all** ancillary providers a copy of the patient's Medicaid Identification Card or, at minimum, the patient's Medicaid Identification number. In addition, when the service requires prior authorization (PA) and a PA number is obtained from Medicaid, please give that PA number to any other provider rendering service to the patient. This will assist other providers who may be required to submit the prior authorization number when billing Medicaid.

5 - 7 Identifying New Patients

A provider may ask new patients for identification, such as picture identification, in addition to the Medicaid Identification Card. Medicaid is a benefit only to eligible patients. Possession of a Medicaid Card does not ensure the person presenting the card is eligible for Medicaid.

6 PROVIDER ENROLLMENT AND COMPLIANCE

This chapter lists general requirements which must be met in order for any provider to participate in the Medicaid Program. SECTION 2 of this manual contains additional requirements for each specific provider type. Medicaid can reimburse a provider who meets all three of the following conditions:

1. Meets all of the credential requirements as listed for each provider type,

2. Completes the Utah Medicaid Provider agreement, and

3. Receives notice from the Utah Medicaid Program that the credentials have been met and the provider agreement accepted.

6 - 1 Provider Agreement

A provider enrolls as a Medicaid Provider by completing the Medicaid Provider Application and signing the Provider Agreement. A provider must execute the Agreement before he/she is authorized to furnish Medicaid services. When the State accepts the provider's application and the agreement is signed, the State will forward a unique Medicaid Provider Identification Number and a Medicaid Provider Manual. The provider's name is placed on the mailing list for Medicaid Information Bulletins.

The following provisions are part of every Provider Agreement, whether included verbatim or specifically incorporated by reference:

1. The provider agrees to comply with all laws, rules, and regulations governing the Medicaid Program.

2. The provider agrees that the submittal of any claim by or on behalf of the provider will constitute a certification (whether or not such certification is reproduced on the claim form) that:

   A. The medical services for which payment is claimed were furnished in accordance with the requirements of Medicaid;

   B. The medical services for which payment is claimed were actually furnished to the person identified as the patient at the time and in the manner stated;

   C. The payment claimed does not exceed the provider's usual and customary charges or the maximum amount negotiated under applicable regulations of the Division of Health Care Financing; and

   D. The information submitted in, with, or in support of the claim is true, accurate, and complete.

6 - 2 Ineligibility of Provider

The Division of Health Care Financing may refuse to grant provider privileges to anyone who has been convicted of a criminal offense relating to that person's involvement in any program established under Titles XVIII, XIX, or XX of the Social Security Act, or of a crime of such nature that, in the judgment of the Department, the participation of such provider would compromise the integrity of the Medicaid Program. The Division may terminate any provider from further participation in Medicaid if the provider fails to satisfy all applicable criteria for eligibility.

6 - 3 Title XIX of the Social Security Act

While enrolled as a Medicaid Provider, a provider must comply with the provisions of Title XIX of the Social Security Act and all applicable State and Federal regulations and standards listed in this chapter.

6 - 4 Civil Rights Compliance; Discrimination Prohibited

When providing medical assistance under programs administered by the Utah State Department of Health, a provider must agree to provide services in accordance with Title VI of the Civil Rights Act as well as other federal provisions which prohibit discrimination against any employee or applicant for employment based upon race, age, color, sex, creed, national origin or disability. Other civil rights laws include Section 504 of the Rehabilitation Act, as amended; the Age Discrimination Act of 1975, as amended; the Americans with Disabilities Act of 1990, as amended; and Title IX of the Education Amendments of 1972, as well as other related laws. Restrictions to individual patient care, based upon the limits placed upon provider practice by specialty, and because of medically related determinations made within the scope of practice, do not constitute violation of the Civil Rights Act provisions.

The Centers for Medicare & Medicaid Services (CMS) is committed to ensuring that there is no discrimination in CMS programs, including Medicaid and the Children's Health Insurance Program. All beneficiaries shall have equal access to and receive the best health care possible regardless of race, color, national origin, age, sex, or disability. The regular program review and audit activities will include: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance; reviewing CMS publications, program regulations, and instructions to assure support for civil rights; and working closely with the Department of Health and Human Services (DHHS), Office of Civil Rights, to initiate orientation and training programs on civil rights. Financial resources will also be allocated to the extent feasible to ensure equal access; prevent discrimination; and assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex, or disability.

DHHS seeks voluntary compliance to resolve issues of discrimination whenever possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. To enforce civil rights laws, the Office for Civil Rights may (1) refer matters for an administrative hearing which could lead to suspending, terminating, or refusing to grant or continue Federal financial assistance; or (2) refer the matter to the Department of Justice for legal action.

6 - 5 Liable Third Parties

A liable third party is any person or entity such as health insurance, a health maintenance organization, or Medicare, which may be responsible for services rendered to a Medicaid patient. This information is available from Medicaid and is printed on the Medicaid Identification Card. Refer to Chapter 5 - 5, Third Party Liability.

1. Medicaid and Other Third Party Coverage: Accepting Patients with Dual Coverage

When a Medicaid client also has some other third party insurance, a provider may either accept the patient as having dual coverage OR not accept either type of coverage. Federal Medicaid regulations do not permit a provider to reject Medicaid and accept only the other third party coverage. A provider can only refuse Medicaid and insist the client must be "private pay" IF there's no other third party coverage. Of course, the Medicaid agency urges that providers accept the client as a Medicaid client, then follow the procedures outlined in the Utah Medicaid Provider Manual for billing TPL. Refer to SECTION 1, Chapter 11, Billing Claims.

Reference: 42 CFR 447.20 (b)

2. Correcting Third Party Information

If information about the responsible third party appears to be incorrect (for example, the TPL denies a claim as "patient not eligible"), the provider should advise the patient to call the TPL unit in the Office of Recovery Services at the Department of Human Services. Providers may also call the Office of Recovery Services to advise them of correct third party liability information. The telephone number is printed on the bottom of the Medicaid Card and also listed in Chapter 5 - 5, Third Party Liability. Refer to Chapter 11 - 4, Billing Third Parties, for information on billing TPL and coordination with Medicaid.

6 - 6 Billing Medicaid

The provider may bill Medicaid only for services which were medically indicated and necessary for the patient and either personally rendered by him/her or rendered incident to his/her professional service by an employee under immediate personal supervision, except as otherwise expressly permitted by Medicaid regulations. The billed charge may not exceed the usual and customary rate billed to the general public, such as individual patient accounts or third party payor accounts.

6 - 7 Medicaid as Payment in Full; Billing Patients Prohibited

A provider who accepts a patient as a Medicaid, Baby Your Baby, or Primary Care Network patient must accept the Medicaid or state payment as reimbursement in full. A provider who accepts a patient enrolled by Medicaid in a managed care plan must accept the payment from the plan as reimbursement in full. If a patient has both Medicaid and coverage with a responsible third party, do not collect any co-payment usually charged at the time of service. The provider may NOT bill the patient for services covered by any of these programs or a managed care plan. The payment includes any deductible, coinsurance or co-payment required by any other third party, such as insurance or Medicare. Medicaid claim forms and the completion of the claim forms are considered part of the services provided and cannot be charged to Medicaid patients.

The only exceptions to the general rule of accepting the Medicaid payment as reimbursement in full are in Chapter 6 - 8, Exceptions to Prohibition on Billing Patients. Providers must follow policies and procedures concerning, but not limited to: medical services covered; medical service limitations; medical services not covered; obtaining prior authorization; claim submission; reimbursement; and provider compliance, as set forth in the Medicaid and Primary Care Network Provider Manuals, Medicaid Information Bulletins, and letters to providers. If a provider does not follow the policies and procedures, the provider may not seek payment from the patient for services not reimbursed by Medicaid or Primary Care Network. This includes services that may have been covered if the provider had requested and obtained prior authorization.

A provider who fails to follow Medicaid policy and is not reimbursed for services rendered may NOT subsequently bill the Medicaid patient. For example, if the provider submits a request for prior authorization, and the request is denied pending additional documentation, the provider must submit the documentation and obtain authorization, rather than billing the patient for services rendered.

Providers who serve people with a Qualified Medicare Beneficiary Identification (QMB) Card must accept the Medicare payment and the Medicaid payment, if any, for coinsurance and deductible as payment in full. Providers may not bill patients eligible for the Qualified Medicare Beneficiary Program for any balance remaining after the Medicare payment and the QMB coinsurance and deductible payment from Medicaid. (Federal reference: 42 CFR 447.15)

6 - 8 Exceptions to Prohibition on Billing Patients

The four circumstances explained in this chapter, items 1 through 4, are the ONLY circumstances in which a provider may bill a Medicaid patient. They are non-covered services, Form MEEU attached to Medicaid Identification Card; Medicaid co-payments and co-insurance; and broken appointments. The specific policy in each item must be followed before the Medicaid patient can be billed.

1. Non-Covered Services

A non-covered service is a service not covered by a third party, including Medicaid. Since the service is not covered, any provider may bill a Medicaid patient when **four conditions are met:**

A. The provider has an established policy for billing all patients for services not covered by a third party. (The charge cannot be billed only to Medicaid patients.)

B. The patient is advised **prior to receiving** a non-covered service that Medicaid will not pay for the service.

C. The patient agrees to be personally responsible for the payment.

D. The agreement is made in writing between the provider and the patient which details the service and the amount to be paid by the patient.

Unless all conditions are met, the provider may not bill the patient for the non-covered service, even if the provider chooses not to bill Medicaid. Further, the patient's Medicaid Identification Card may not be held by the provider as guarantee of payment by the patient, nor may any other restrictions be placed upon the patient.

2. Form MEEU attached to Medicaid Identification Card

The patient's Medicaid Identification Card has the message "IMPORTANT! MEDICAID WILL NOT PAY FOR SERVICES ON ATTACHED FORM MEEU" printed below the recipient eligibility information and above the recipient name. (The Interim Verification Form 695 has a stamped message: "NOT VALID WITHOUT MEEU ATTACHED.") An example of the card is included with the Medicaid Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual. When you see either message, look at Form MEEU, "Medical Expenses Used." If Form MEEU is missing, ask the recipient to obtain another copy, use Medicaid On-Line to access the information, or call Medicaid Information. Refer to Chapter 12, Medicaid Information. An example of a Medicaid card with the message and Form MEEU are included with the Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Any provider whose service is listed on the Form MEEU should collect from the patient the amount the patient is responsible to pay. Beneath the provider's name and address is printed the date of service, type of service, the total bill for that service, and the recipient's financial obligation, as determined by the Medicaid eligibility worker at the time the form was issued. Collect from or bill the patient for the amount indicated.

Bill Medicaid the full charge for the service. Do NOT bill a partial charge to Medicaid. If the recipient owes you the full amount of the charge, you may choose not to bill Medicaid.

When your claim is received, Medicaid bases the reimbursement amount on the amount you billed, or the standard reimbursement amount, whichever is less. (This is why a provider should not bill a partial charge. A partial charge might be less that the Medicaid reimbursement amount.) Medicaid deducts the client's obligation from the Medicaid reimbursement amount. The remainder is paid to the provider. When the client's obligation to pay is equal to or more than the Medicaid reimbursement amount, the Medicaid payment will be zero.

For more information on this financial obligation, refer to Chapter 1 - 1, Applying for Medicaid, subsection titled Medicaid Medically Needy Program (Spenddown).

3. Medicaid Co-payments, Co-insurance

Many adult Medicaid clients are required to make a co-payment or co-insurance for the types of services listed below. Co-pay refers to either a co-payment or co-insurance The effective date of the requirement is in parentheses below:

- pharmacy (July 1, 1997)
- non-emergency use of a hospital emergency department (January 14, 1994)
- office visits performed by a physician or podiatrist and for outpatient hospital services (November 1, 2001)
- rural health clinic services (April 1, 2002)
- inpatient hospital services (January 1, 2002).

Both HMO and fee-for-service clients can have a payment. The client's Medicaid Identification Card will state when a co-pay is required. The provider is responsible to collect the co-pay at the time of service or bill the client. The amount of the client's co-pay will automatically be deducted from the claim reimbursement.

Co-Pay Message on Medicaid Card, by Client

The Medicaid Card will say "COPAY/CO-INS" by the individual client's name if he or she has a co-pay. The message will say what type of co-pay to collect. Below is an example of how the co-pay message may appear:

NAME
Smith, John Q
Copay/co-ins for: non-emergency use of the ER, outpat hosp & physician svcs, pharmacy, inpat hosp

The co-pay message may vary by client and whether the client is in an HMO or is fee-for-service. If there is no message by a client's name, the client does not have a co-pay. A family may contain an adult with a co-pay and children who are exempt. So you must verify whether the individual patient has a co-pay for the type of service.

No Co-pay for Exempt Services

Some services are exempt from co-pay. It does not matter whether the client has a co-pay or not. Do not collect a co-pay for the following types of service:

1. Family planning services have NO co-pay.
2. Emergency services in a hospital emergency department have NO co-pay. However, non-emergency use of a hospital emergency department may require a co-pay. Refer to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 2 - 1, Co-payment Requirement: Outpatient Hospital and Non-emergency Use of a Hospital Emergency Department.
3. Lab and X-ray services, including both technical and professional components, have NO co-pay.
4. Anesthesia services have NO co-pay.

Collecting a Co-pay

Before you collect a co-pay, be sure the client has a co-pay and that the service requires a co-pay. For more information on the co-pay requirement for specific types of services, refer to SECTION 2 of the appropriate Utah Medicaid Provider Manual:

- Physician Services, Chapter 1 - 5
- Podiatry Services, Chapter 1 - 3
- Hospital Services, Chapter 2 - 1
- Pharmacy Services, Chapter 1 - 8
- Rural Health Clinic Services, Chapter 1 - 5

Please give the client a receipt for the co-pay collected. We will urge clients to keep co-pay receipts in case of delayed billings by providers or discrepancies. If you do not collect a co-pay owed at the time of service, you may bill the client for the amount that should have been paid.

Clients Exempt from Co-pay

The Medicaid card states whether an individual client has a co-pay. A client in one of the following groups does not have a co-pay.

- child under age 18.
- pregnant woman.
- total gross income, before exclusions or deductions, is below the Temporary Assistance to Needy Families (TANF) standard payment allowance, as determined by an eligibility worker.
- resident of a nursing home.
- QMB ONLY [Qualified Medicare Benefits]
- Medicaid/QMB clients, except for pharmacy services and non-emergency use of the emergency room as stated on the Medicaid ID Card.18.
- co-payment maximum out-of-pocket has been met.

Pregnant Woman Exempt from Co-Pay

Do not require a co-pay for services to a pregnant woman, even if there is a co-pay message by her name on the Medicaid Identification Card. Add pregnancy diagnosis V22.2 to the claim. Encourage the woman to report her pregnancy to the Medicaid eligibility worker, who can change her co-pay status to exempt on future Medicaid cards.

Co-pay Maximums Per Client

There is no maximum on co-pays for non-emergency use of the Emergency Department. Other co-pays and co-insurance have a maximum out-of-pocket per client, per type of service. When a client meets the maximum out-of-pocket payment for a type of service, as determined by Medicaid billing information, the following month the co-pay message will change. For example, a client may meet the maximums for physician and inpatient hospital services and continue to have a co-pay for pharmacy and non-emergency use of the Emergency Department. The box below has an example of a co-pay message.

4. Broken appointments

A broken appointment is not a service covered by Medicaid. Since the charge is not covered, any provider may bill a Medicaid patient when **three conditions are met**:

A. The provider has an established policy for acceptable cancellations. For example, the patient may cancel 24 hours before the appointment.

B. The patient has signed a statement agreeing to pay for broken appointments.

C. The provider charges all patients in the practice for broken appointments. The charge cannot be billed only to Medicaid patients.

NAME
SMITH, JOHN Q
COPAY/CO-INS FOR: NON-EMERGENCY USE OF THE ER, PHARMACY

6 - 9 Physician Referrals

When the Medicaid patient has a Primary Care Provider, this provider must provide an appropriate referral before Medicaid will pay for medical services received from any other provider. Only a Medicaid client's Primary Care Provider can provide a referral to a consulting physician. If the consulting physician determines a need for the client to be seen by a second consulting physician, the Primary Care Provider must provide another referral. The consulting physician may NOT provide the referral in lieu of the Primary Care Provider. The Primary Care Provider Physician may make any referral in writing or verbally.

Physicians who make referrals to another provider should consider that Medicaid limits medical transportation to the nearest provider or the nearest appropriate facility which can provide the needed services. Therefore, if the client does not have his or her own transportation, and must use medical transportation covered by Medicaid, the referral must be to the nearest provider or the nearest appropriate facility which can provide the needed services. This limitation includes all medical transportation, in both emergency and non-emergency situations.

Documenting the Referral
Both the referring physician and the servicing provider are responsible for documenting that the Primary Care Physician authorized the referral. When Medicaid conducts a post-payment review, ALL of the following information must be entered in the patient's records to document the referral:

- the date the Primary Care Physician contacted the servicing provider
- Primary Care Physician's name
- Primary Care Physician's number in the format as specified in rule 590-164 on file with the Insurance Commission;
- patient's name;
- patient's Medicaid Identification Number;
- patient's date of birth; AND
- any clinical information that is pertinent to the referral.

Billing claims based on a referral
Follow the HCFA-1500 instructions for entering the referring provider's number on the claim form.

6 - 10 Physician Ownership and Prohibition of Referrals

A physician or immediate family member of the physician who has a financial interest in a health service should be aware of Federal regulations in Section 13562 of the Omnibus Reconciliation Act (OBRA) of 1993. A physician with a financial interest in a health service may not make a referral to that service when payment would be made as a result. The health service may not send a bill to an individual nor file a claim with a third party for services provided as a result of such a referral.

A financial interest may be through ownership, or through a direct investment interest (such as holding equity or debt), or through another investment which has ownership or an investment interest in the health service.

6 - 11 Ensure All Medically Necessary Services and Medicaid Coverage

A Medicaid provider who accepts a Medicaid client for treatment accepts the responsibility to make sure the client receives all medically necessary services. A provider's responsibilities include making referrals to other Medicaid providers; ensuring ancillary services are also delivered by a Medicaid provider; and ensuring the client receives all medically necessary services at no cost.

A. **Quality of Care**
   A provider who accepts a Medicaid patient for treatment accepts the responsibility to make sure that the patient receives **all** medically necessary services from enrolled Medicaid practitioners who meet all requirements of the Utah Medicaid program, who agree to abide by Medicaid rules to provide medically necessary services, and who accept the Medicaid reimbursement as payment in full. This includes physicians, surgeons, anesthesiologists, laboratory, X-ray, pharmacy, rehab and other providers on staff.

B. **Appropriate Referrals**
   When the Medicaid patient has a Primary Care Provider, the provider must provide an appropriate referral before Medicaid will pay for medical services received from any other provider. The other provider must be a Medicaid provider as well. Refer to Chapter 6 - 9, Physician Referrals.

C. **Ancillary Services by Participating Provider**
   Make sure ancillary services, such as lab, x-ray, and anesthesiology, are delivered by a participating Medicaid provider. Please give **all** ancillary providers a copy of the patient's Medicaid Identification Card or, at minimum, the patient's Medicaid Identification number. In addition, when the service requires Prior Authorization (PA) and a PA number is obtained from Medicaid, please give that number to other providers rendering service to the patient. This will assist other providers who may be required to submit the prior authorization number when billing Medicaid.

6 - 12 Medical Interpretive Services

Medicaid providers are required to provide foreign language interpreters for Medicaid clients who have limited English proficiency. Clients are entitled to an interpreter to assist in making appointments for qualified procedures and during visits. Providers must notify clients that interpretive services are available at no cost. We suggest providers encourage clients to use professional services rather than relying on a family member or friend, though the final choice is theirs. Using an interpretive service provider ensures confidentiality as well as the quality of language translation. Accuracy of translation is especially important in health care visits.

Client Enrolled in a Managed Care Plan
Always verify whether a patient is covered by a managed care plan such as a health maintenance organization or Prepaid Mental Health Plan. If the service needed is covered by a managed care plan, contact the plan to obtain an interpreter. References: Utah Medicaid Provider Manual, SECTION 1, Chapter 4, Managed Care Plans, and Chapter 5, Verifying Medicaid Eligibility.

Fee-for-Service Clients
Medicaid will cover the cost of an interpreter when three conditions are met.

1. Client is eligible for a federal or state medical assistance program. Programs include Medicaid, CHIP, and services authorized on a State Medical Services Reimbursement Agreement Form (MI-706).
2. Client is fee-for-service, as defined in SECTION 1, Chapter 3.
3. The health care service needed is covered by the medical program for which the client is eligible. Services covered by Medicaid are listed in SECTION 1, Chapter 2, COVERED SERVICES.

When the three conditions of coverage are not met, the provider may be responsible for the cost of interpretive services. The provider may NOT bill the client for the service except under the conditions stated in SECTION 1, Chapter 6 - 8, Exceptions to Prohibition on Billing Patients.

How to Obtain An Interpreter
Medicaid offers a "Guide to Medical Interpretive Services." The guide lists client eligibility requirements, contractors, languages offered, and information required from the provider. The guide is in the GENERAL ATTACHMENTS Section of this Provider Manual and also available on the Medicaid web site. Look for the link on the Provider Guide at: http://health.utah.gov/medicaid/provhtml/provider.html.

6 - 13 Recovery of Payments for Non-Covered Services

When Medicaid pays for a service which is later determined not to be a benefit of the Utah Medicaid Program or not in compliance with State or Federal policies and regulations, Medicaid will make a written request for a refund of the payment. The refund must be made to Medicaid within 30 days of written notification. An appeal of this determination must be filed within 30 days of written notification.

6 - 14 Other Recovery of Payments

When services for which the Medicaid Program provided reimbursement cannot be verified by adequate records as having been furnished, or when a provider unreasonably refuses to provide or grant access to records as described above, either the provider must promptly refund to the State any payments received by the provider for such undocumented services, or the State may elect to deduct an equal amount from future reimbursements.

6 - 15 Administrative Review / Fair Hearing

A provider may request an agency conference or formal hearing if dissatisfied with any decision made by the Division of Health Care Financing. A formal hearing before the Department of Health may be requested within 30 days of the date of the agency action. The request for the agency conference and/or formal hearing must be in writing and sent to:

DIVISION OF HEALTH CARE FINANCING
DIRECTOR'S OFFICE/FORMAL HEARINGS
BOX 143105
SALT LAKE CITY UT 84114-3105

or use FAX number: (801) 538-6478

The agency is not required to grant a hearing if the sole issue is a Federal or State law requiring an automatic change.

6 - 16 Suspension or Termination from Medicaid

The Department may suspend or terminate from Medicaid participation any medical practitioner or other health care professional licensed under state law who is convicted of Medicaid or Medicare related crime(s) in either a federal or state court.

When a practitioner or other health care professional is convicted and sentenced in a state court of Medicaid-related crime(s), the Department shall promptly notify the Department of Health and Human Services, Regional Sanctions Coordinator, and provide the following information within 15 days after sentencing:

A. name and address of the practitioner;
B. date of conviction;
C. statute(s) violated and number of counts;
D. a copy of the indictment; a copy of the plea agreement (if applicable) and the judgment, conviction, or probation order;
F. current address of the practitioner (if the practitioner is incarcerated, provide the name and address of the penal institution); and
G. name and address of the Director of the State local licensing authority.

The Department may request a waiver of suspension or termination if the sanction is expected to have a substantial negative impact on the availability of medical care in the community or area. The waiver request should contain a brief statement outlining the problem, and be submitted to the Centers for Medicare & Medicaid Services (CMS). CMS will notify the Department if and when it waives the sanction. Waivers should only occur if:

A. the Secretary of the Department of Health and Human Services has designated a health manpower shortage area; and
B. an insufficient number of National Health Services Corps personnel has been assigned to the needs of that area.

6 - 17 Medicaid Audits and Investigations

The following is intended as a useful guide regarding Medicaid audit procedures conducted by the Utah Department of Public Safety's Medicaid Fraud Unit and should not be construed to create any independent rights, duties, or requirements and should not be considered as legally binding upon the State, its agents, or employees. This information is not intended as legal advice. You are encouraged to consult a licensed attorney if you have any questions regarding Medicaid audits or investigations.

I. Definitions

1. **Medicaid Audit**: A civil or administrative process of reviewing Medicaid provider records to ensure accurate billing and payment for Medicaid claims.

2. **Investigation**: An official inquiry conducted by law enforcement officers of the Utah Department of Public Safety's Medicaid Fraud Unit, to prove or disprove evidence of criminal conduct. An investigation may begin by auditing provider records.

3. **Audit Settlement**: An agreement to resolve a civil financial Medicaid overpayment dispute when criminal charges are not currently filed.

4. **Plea Agreement**: An agreement made between a prosecutor to resolve pending criminal charges against a Medicaid provider.

5. **Medicaid Fraud Control Unit** (MFCU), formerly Medicaid Fraud Unit (MFU): The official state Medicaid fraud control unit in the Department of Public Safety, certified by the federal government, to investigate and prosecute complaints of abuse and neglect of patients, and Medicaid fraud under state laws as required by 42 CFR §§ 1007.7 through 1007.13. The MFCU has state-wide prosecutorial authority.

6. **Search Warrant**: An order signed by a judge and served by a law enforcement officer, which identifies a specific location, items, or person to be searched based upon a judicial finding that probable cause exists to believe that the property or evidence was unlawfully acquired or possessed, used to commit or conceal the commission of a crime, or is evidence of illegal conduct. See Utah Code §§ 77-23-201 and -202. Search warrants are also governed by the Fourth Amendment of the United States Constitution and article I, section 14 of the Utah Constitution.

7. **Criminal Subpoena**: An order signed by a judge obtained pursuant to a pending criminal investigation filed with the court as required by Utah Code § 77-22-2, which requests the named witnesses testimony or documents possessed by the person upon whom the subpoena is served (Subpoena Duces Tecum). A criminal subpoena is not a search warrant and does not provide authority for the serving office to enter a premise or inspect or seize property or persons.

8. **Medicaid Provider Agreement**: A signed contract between a provider and the Utah Medicaid program by which the provider agrees to abide by all state and federal law related to the Medicaid Program, including providing medical and billing records for the purposes of conducting Medicaid and MFCU audits to determine fraud or abuse of the Medicaid program. Through this agreement, the provider also agrees to abide by any subsequent amendments to the Agreement published in the Medicaid Provider Bulletin. This agreement, together with the recipient's Medicaid application, authorizes the release of Medicaid records for Medicaid and MFCU auditing purposes (See attached provider agreement and Medicaid application).

9. **CFR**: Code of Federal Regulations - Federal executive agencies rules, in this context, promulgated by the Centers for Medicare & Medicaid Services [formerly Health Care Financing Administration (HCFA)] which place requirements upon the state Medicaid agency, Medicaid providers, and recipients.

10. **Medicaid Fraud**: Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive some unauthorized Medicaid benefit for any person or entity. See Utah Code Ann. §§ 26-20-1, et seq.; Utah Administrative Rules, R414-22; and 42 C.F.R. § 455.2. Medicaid fraud violations may also be brought under more general state and federal theft and fraud statutes.

11. **Abuse**: Provider practices that are inconsistent with sound fiscal, business, or medical practices resulting in unnecessary Medicaid costs. Reimbursement for services that are not medically necessary, fail to meet professionally recognized standards of care, or any practice that results in increased costs to Medicaid are also considered abuse. Criminal intent need not be alleged or proved to establish abuse. See 42 C.F.R. § 455.2.

12. **Overpayment**: In this context, when a Medicaid provider receives more Medicaid reimbursement than the provider is entitled, regardless what party is at fault.

II. **Audits and Criminal Investigations**

A. **Identification of Possible Overpayment**: MFCU and the Medicaid Agency identify providers to be audited or investigated through reviews of claims and billing information and referrals and reports from a multitude of sources. Refer to the chart titled "Medicaid Investigations" in the GENERAL ATTACHMENTS Section of this manual.

B. **Initial Review/preliminary investigation**: When MFCU and Medicaid receive information of a possible overpayment, they conduct an initial review. This review may take the form of a civil audit or immediately begin as a criminal investigation.

1. Medicaid Review: The Medicaid agency performs audits to verify whether an overpayment was made to a provider. This process is always an administrative civil function.

2. MFCU Review: All MFCU reviews of overpayments are considered part of the criminal investigation process, even at the audit stage. The mere fact that an audit is being performed by MFCU, however, does not suggest that evidence of criminal wrongdoing exists. The audit may tend to prove or disprove potential fraud allegations.

C. **Results of Initial Review/preliminary investigation**:

1. Medicaid Results: If the preliminary investigation reveals abuse, a full investigation will be conducted if necessary to fully substantiate the extent of the abuse. Medicaid will then proceed through an administrative hearing process to collect the overpayment. However, the matter is referred to MFCU if evidence of fraud is discovered.

2. MFCU Results: If the initial review indicates substantial potential for criminal prosecution, a criminal investigation will be conducted by MFCU. If the initial review does not substantiate criminal conduct, the matter may be referred to the state Medicaid agency for collection or other action. However, MFCU is authorized to attempt to collect any identified overpayment even in the absence of criminal conduct, but must send claims to the Medicaid Agency if they are unsuccessful in their civil collection efforts (See 42 CFR § 1007.11).

D. **Privacy Rights**: Medicaid and MFCU must safeguard the privacy rights of providers and Medicaid recipients during all aspects of an initial review, audit, and criminal investigation (See 42 CFR § 1007.11(f)).

III. **Obtaining Provider Medicaid Records**:

A. **Three Ways to Obtain Records**:

1. The MFCU may lawfully obtain Medicaid provider records by:
   a. Requesting records for investigative purposes as authorized by the provider agreement and recipient application;
   b. Serving a criminal subpoena upon the provider; and
   c. Serving a search warrant.

2. Medicaid obtains records through the provider agreement or administrative subpoena.

B. **Access through Medicaid Provider Agreement:** Both Medicaid and MFCU can obtain access to Medicaid medical and billing records as authorized by the Provider Agreement and recipient application. The Medicaid Provider agreement requires a provider to allow access to, or copies of, medical and billing records for at least five years. Providers must allow access, during normal business hours, within 24-hours when "immediate access" is requested by Medicaid or MFCU.[1] Failure to provide records under the Provider Agreement can result in penalties, including exclusion from the Medicaid program. Medicaid and MFCU should give providers a reasonable time period in which to provide access to the records when "immediate access" is not requested. When appropriate, providers will be contacted in writing or by telephone call to give advance notice of records request. Records access sought under the Provider Agreement, rather than through judicial subpoenas and search warrants, is considered the least intrusive means of obtaining records. A provider need not turn over original records, but must allow inspection of the originals or copies to be made. A provider or an employee of a provider may be asked questions, as consented to by the provider or employee, regarding the records and billing practices of a provider. However, the provider and the employee have the right to remain silent if what they say may implicate them in criminal conduct.

C. **Criminal Subpoenas:** Criminal subpoenas are governed by Utah Code § 77-22-1 through 5. Before a law enforcement officer can obtain a criminal subpoena, a criminal investigation case must be opened with, and approved by, a state district court after a showing of "good cause." A prosecutor must apply to the district court for each subpoena prior to it being served.

1. **Contents of Subpoenas:** The prosecutor must state in each subpoena the time and place of the interrogation or production of records, a description of the records requested if a subpoena duces tecum, that it is issued in aid of a criminal investigation, and that the witness has a right to have counsel present (for any interrogations). Utah Code § 77-22-2(3). No right to compel testimony or interrogate exists by the mere serving of a subpoena requesting only documents

2. **Disclosure by Prosecutor for Compelled Testimony:** The prosecutor must personally inform the witness at the beginning of each compelled interrogation of the general subject of the investigation, the right of the witness to refuse to answer any question that may result in self-incrimination, and the right to have counsel present. If the prosecutor has "substantial evidence" that the witness has committed a crime that is under investigation, the prosecutor must so inform the witness and disclose the nature of the contemplated charges prior to the interrogation. Utah Code §§ 77-22-2(4) and (5).

3. **Witness fees** and expenses such as copy costs and mileage must be paid as required in a civil action. The witness fee should be tendered at the time of serving the subpoena. Utah Code § 77-22-2(6)(b).

4. **Time and Place to Produce Records:** A provider served with a criminal subpoena requesting records, generally need not copy records or provide access when service is made. The subpoena will state the time and place when the documents must be delivered or relevant objections made.

5. **Access to Original Records:** A provider need not provide original records pursuant to a subpoena as long as access to, or copies are made of, the original records.

D. **Search Warrant:** Medicaid documents and any other property in the custody of a Medicaid provider may be seized by a law enforcement officer in the process of executing a valid search warrant. A search warrant must specify the place, location, and the items to be seized. A search warrant is only valid when signed by a judge after a finding of probable cause, which is the same standard necessary to arrest a private citizen for criminal conduct. Patient records seized pursuant to a search warrant must be the original records and a receipt must

[1] Failure to grant immediate access may result in punitive administrative measures against a provider who does not comply with a reasonable request within 24-hours. A reasonable request means the delivery of a written statement of what records are requested, the authority possessed by the requestor of the records, and the penalties for failing to comply within 24-hours of the request.

be provided for the records to the provider by the officer. However, it is the practice of MFCU to provide copies of the records to the provider so that patient care will not be adversely impacted. See Utah Code §§ 77-23-1, et seq. No right to compel testimony or interrogate witnesses exists solely on the basis of a search warrant. A search warrant only authorizes a law enforcement officer to search and seize items as specified in the warrant.

IV. **Agreements to Resolve Overpayments**

A. **Settlements:** Overpayments identified by a Medicaid or MFCU audit may be settled as any other civil claim. MFCU investigators may not offer to settle an overpayment dispute in exchange for not pressing or filing criminal charges. The agreement should clarify whether it can be used as evidence of fraud or abuse or in collateral actions against a provider's professional licenses or to terminate a provider agreement.

B. **Plea Bargain:** After criminal charges are filed with the district court against a provider, that provider and the prosecutor may enter into a plea bargain agreement. Such an agreement may include paying a fine, penalty, cost of investigation, and overpayment in exchange for a plea, plea in abeyance, or a diversion agreement to the pending charge or a lessor crime. Plea bargains generally resolve all known overpayment issues and purported criminal conduct. Plea bargains may result in a conviction, may serve as a basis to revoke a professional license, association membership, terminate a Medicaid provider agreement, and your name may be added to a federal fraud and abuse data base.

V. **Complaints and Appeals**

A. MFCU Complaints regarding investigations and personnel misconduct should be directed to:

Director
Division of Criminal Investigations and Technical Services
Office of the Attorney General
Medicaid Fraud Control Unit
5272 South College Drive, Suite 200
Murray, Utah 84123

(801) 284-6200

B. Complaints regarding procedures of the MFCU should be directed to:

MFCU Director
Division of Investigations
Office of the Attorney General
Medicaid Fraud Control Unit
5272 South College Drive, Suite 200
Murray, Utah 84123

(801) 284-6218 or (801) 826-2215

C. **Medicaid Administrative Appeals:** Disputes regarding overpayments or audit findings may be appealed through the normal Medicaid administrative hearings process. Call (801) 538-6576 for further information or send appeals to:

Division of Health Care Financing
Medicaid Operations
Formal Hearings
P.O. Box 143105
Salt Lake City, Utah 84114-3105

6 - 18 Employment of Sanctioned Individuals

Federal Fraud and Abuse regulations adopted by the Health and Human Services Office of Inspector General in compliance with both HIPPA (Public Law 104-191) and The Balanced Budget Act of 1997 (Public Law 105-33), identify significant civil and criminal actions that may be taken against Medicaid providers who employ federally sanctioned individuals. This is true even if the sanctioned individual does not work directly in providing services to individuals under the Medicaid program.

Providers need to be aware that it is their responsibility to verify that the individual is not on a federal sanctions list. If a provider does employ an individual who is on the federal sanctions list, and that person provides services which are directly or indirectly reimbursed by a federally funded program, the employer may be subject to legal action which could include civil penalties, criminal prosecution and/or exclusion from program participation.

It is essential that providers regularly check the federal sanctions list which can be found at: www.oig.hhs.gov/fraud/exclusions/listofexcluded.html. It would be advisable for all providers to check current and potential employees against the list on the federal database to ensure that no sanctioned individuals are working for their organization.

7 MEDICAL STANDARDS - MEDICAL NECESSITY

A provider must furnish or prescribe medical services to the patient only when, and to the extent that, it is medically necessary. A service is "medically necessary" if it is reasonably calculated to prevent, diagnose, or cure conditions in the patient that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a disability, and there is no other equally effective course of treatment available or suitable for the patient requesting the service which is more conservative or substantially less costly. Medical services will be of a quality that meets professionally recognized standards of health care, and will be substantiated by records including evidence of such medical necessity and quality. Those records will be made available to the Department upon request.

7 - 1 Determining Compliance with Standards

A provider's failure to comply with medical standards, Federal audit, quality assurance review, or prior authorization requirements may be determined by peer review. Initial determinations as to whether or not a provider has failed to comply will be made by Division of Health Care Financing employees or consultants. If the determination of a noncompliance is made, the Division of Health Care Financing will notify the provider in writing pursuant to the notice provisions of the Administrative Hearing Procedures of the failure to comply.

Either the Division of Health Care Financing or the provider may request to have formal peer review of the determination. A written request by either the Division or the provider for formal review must be made within 30 days following the date of the original notice to the provider of the determination of a noncompliance. The written request from the provider must be submitted by him/her to:

DIVISION OF HEALTH CARE FINANCING
BUREAU OF COVERAGE & REIMBURSEMENT POLICY
ATTN: PEER REVIEW
BOX 143102
SALT LAKE CITY UT 84114-3102

The written request will be submitted to the appropriate Professional Society requesting that a Peer Review Committee conduct a formal peer review of the determination. The informal hearing requirements of Sec. 26-23-2-(1) UCA, (1953) are satisfied by the professional peer review process.

If either the Division of Health Care Financing or the provider is dissatisfied with the results of the informal peer review, they may request a formal hearing before the Department of Health in accordance with the formal hearing procedures set forth by the Division of Health Care Financing Administrative Hearing Procedures.

In situations of violations of compliance of professionally recognized medical standards, as identified by peer review, the Division of Health Care Financing may pursue any legal sanction for recovery of overpayments.

If the provider is found at fault, and Federal Financial Participation is disallowed on reimbursements made to the provider, the provider must reimburse to the State the total amount the State paid for the services disallowed.

7 - 2 Experimental or Unproven Medical Practices

Experimental or unproven medical practices are not a benefit of the Medicaid Program. Experimental practices include any services which are investigational or experimental in nature and/or are performed in conjunction with or by persons who are using such services to generate data to support or contribute in any way to research grants, studies or projects, or testing of new processes or products, regardless of sources of support or funding for such projects or any parts of such projects.

Although some services have been shown to provide some medical benefit for certain medical conditions, such services will not be covered for other conditions unless medical efficacy is proven. Examples of such medically unproven treatments include, but are not limited to, plasmapheresis in multiple sclerosis and renal dialysis in schizophrenia.

Unless billed services are proven to be medically efficacious as determined by the Centers for Medicare & Medicaid Services, payment will be denied by Medicaid. Final determination is made by the Department of Health and Human Services.

7 - 3 Payments Recovered

If experimental services or unproven medical practices are billed to and paid by Medicaid, payments for the services in question, along with payments for all supporting services (although though not experimental) will be refunded to the Medicaid Program. Supporting services may include but are not limited to supplies, laboratory, x-ray, inpatient and outpatient hospital services, physician, pharmacy, therapist and transportation.

8 CODING

Medicaid recognizes guidelines in current editions of established coding Manuals or other standard literature. However, those guidelines are adopted only as far as they are consistent with application to Medicaid Policy. The established coding guidance materials consist of the following:

- Physicians' Current Procedural Terminology (CPT) Manual
- Healthcare Common Procedure Coding System, HCPCS Level II
- Healthcare Common Procedure Coding System, HCPCS Level III
- International Classification of Diseases, 9th Edition, Clinical Modification, (ICD.9.CM), Volumes 1, 2, and 3
- Revenue Codes (Uniform Billing Codes - UB-92)

8 - 1 Healthcare Common Procedure Coding System (HCPCS)

The HCPCS System incorporates the American Medical Association, Current Procedural Terminology Manual(CPT) as Level I of the system. CPT represents the major portion of the HCPCS system. CPT uses 5 digit numeric codes and a uniform language to accurately classify medical, surgical, and diagnostic services for effective communication among health care providers, health care facilities, and third party payers. Although the CPT Manual is primarily for physician use, other providers may be authorized by Medicaid policy to use the codes and descriptors if other HCPCS codes are not available or appropriate.

HCPCS Level II codes are alphanumeric codes which are uniform in description throughout the United States. The codes begin with a letter followed by four numbers. The descriptions cover equipment, supplies, materials, injections and other items used in health care services. Although the codes and descriptors are uniform, processing and reimbursement of HCPCS Level II codes is not necessarily uniform throughout all states.

HCPCS Level III codes are alphanumeric codes established locally by Medicare, Medicaid and other third party payers to meet the needs of various local program policy. Alphanumeric "Y" codes are Utah Medicaid specific. With the implementation of the Health Insurance Portability and Accountability Act (HIPPA), the local alphanumeric codes, including Medicaid "Y" codes, will be replaced with standard HIPPA codes.

8 - 2 Classification Coding

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD.9.CM) is a statistical classification system that arranges diseases and injuries into groups according to established criteria. Three to five digit numeric codes are used as identifiers. ICD.9.CM Volumes 1 and 2 provide guidelines for coding and reporting diseases, injuries, impairments, related health problems and their manifestations, and the causes of injury, disease, impairment or other health related problems. Volume 3 identifies procedures or other actions taken to address diseases, injuries, and impairments involving hospital inpatients.

A. **Revenue Codes (Uniform Billing Codes UB-92)**

Uniform billing guidelines are a standard data set and format used by the health care community to transmit charge and claim information on hospital services to third party payers. The guidelines are developed on a national basis by the National Uniform Billing Committee. The Billing Manual is maintained and updates provided locally by the Utah Hospital and Health Systems Association. The approved codes in the Medicaid section of the UB-92 Manual are established consistent with Medicaid policy, reviewed and maintained by Medicaid staff periodically.

B. **Coding Maintenance**

Industry updates to CPT, HCPCS, and ICD.9.CM codes are published toward the end of each year. Medicaid staff review each new edition of the coding manuals. The purpose of the review is to identify new services, eliminated services or procedures, and altered descriptions of service. Where additions, deletions, and/or changes have occurred, research is initiated with subsequent development of appropriate policy recommendations and rulemaking to establish service coverage and/or limitations consistent with Medicaid policy. Notice of any change is given in the Medicaid Information Bulletin. All codes will be discontinued or added based on the date of implementation set by the standard setting organization.

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8 - 3 Classifying Patients as 'New' or 'Established'

Providers must observe CPT and Medicaid guidelines on classifying a patient either as *new* or as *established*. Page 1 of the Physician's Current Procedural Terminology Manual (CPT) defines "New and Established Patient" as follows:

"A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department."

Medicaid Guidelines

Medicaid has guidelines in addition to those in the CPT Manual.

A. **Established Patient**

Medicaid considers an established patient as one who has received professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

1. When a physician is on call for or covering for another physician, classify the patient's encounter as it would have been by the physician who is not available.

2. Medicaid considers any physician in the same clinic, group practice or other facility to be "of the same specialty" unless the patient has specifically been referred to another physician of a different specialty for issues related to that specialty.

B. **New Patient**

Providers may bill for a 'new patient' when the person has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, with in the past three years.

C. **Patients Seen in an Emergency Department**

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment

in the emergency department. Medicaid considers the term "emergency department" to be a designated emergency unit of a licensed hospital. No other facility or location will qualify under Medicaid as an "emergency department".

8 - 4 Diagnosis Must Agree with Procedure Code; Use of 'V' Codes

Effective January 1, 2002, claims must have a diagnosis that fits the procedures completed, or they will be denied. A diagnosis code in addition to the V code must also be on the claim form. Make sure that the diagnosis and procedure codes agree!

Here are two examples:

A. V code V10, personal history of malignant neoplasm, or V10.3, – breast, should be accompanied by other ICD.9 codes indicating the differential diagnoses that led to a decision for CT scans of the brain and spine. Chosen ICD.9 codes should reflect symptoms and/or indications that led to the decision for extensive imaging, laboratory tests, and/or a procedure.

B. When using V code V67, follow up examination, include the code related to the original surgery, injury, or fracture.

Procedures for Children

When the majority of procedures are basically related to a routine health visit and/or childhood immunizations, V codes related to routine child health examinations, such as V20, V20.0, V20.1, V20.2 will be accepted alone for payment. However, when the child also has a medical condition that requires additional procedures (such as x-rays, laboratory examinations, etc.), place on the claim the ICD.9-CM code which describes the differential diagnoses for the medical condition. The ICD.9 codes assist in explaining the diagnostic test.

Diagnosis and Procedure Incomplete, or Not in Agreement

Past claims reviewed using the clinical claims editor program show numerous instances where the diagnosis does not fit the procedures listed on the claim, or the claim is submitted with only a V-code for the diagnosis. Claims submitted with only a V code will not be paid, with the exception of child health exams. Claims submitted with a diagnosis which does not agree with the procedure completed will be denied. Here is an example: A claim for CT of the abdomen which is submitted with diagnoses of headache and myalgia will not be paid.

Medicaid must have an accurate record of the diagnosis and procedures on submitted claims to evaluate programs and payment trends, and have accurate records. Claim payment to providers is delayed when inaccurate diagnoses are submitted. Other insurance providers including Medicare are using editing programs that review procedure to diagnosis issues. If you have questions, call Medicaid Operations. Staff can assist with training and/or provide a list of procedure-to-diagnoses for a particular issue of concern.

8-5 Procedures with Time Definitions

Many procedure codes contain time frames built into the definition. For billing services that fall between the time frames, Medicaid's policy is to round to the nearest full unit or appropriate procedure code. No partial units may be reported.

9 PRIOR AUTHORIZATION

Prior authorization is an approval given by the Medicaid agency, prior to services being rendered, for procedure codes identified in SECTION 2 as requiring prior authorization. Approval must be obtained precedent to service being provided. Prior authorization confirms that services requested are needed, that they conform to commonly accepted medical standards, and that all less costly or more conservative alternative treatments have been considered. Prior authorization does not guarantee reimbursement. All other Medicaid requirements must be met in order for a provider to receive reimbursement.

A. Prior authorization (PA) requirements apply ONLY for services which may be covered directly by Medicaid. These include services for a patient assigned to a Primary Care Provider or services not included in a contract with a managed care plan.

B. The PA requirements and process do not apply for services covered by a managed care plan when the Medicaid patient is enrolled in that managed care plan. Each plan specifies which services it covers, which require authorization, and the conditions for authorization. Because information as to what plan the client must use is available to providers, the provider must follow the plan's procedures for authorization in order to receive reimbursement.

   Medicaid cannot process requests for prior authorization for services included in a contract with a managed care plan. Providers requesting services for a client enrolled in a managed care plan will be referred to that plan. When the client is enrolled in a managed care plan, and Medicaid staff prior authorize a service in error, instead of referring the provider to the client's plan, Medicaid cannot pay for the service. If the provider fails to follow the plan's procedures for authorization, the managed care plan may also refuse to pay for the service.

C. If a provider is required to obtain prior authorization, fails to do so, provides service anyway, and then bills Medicaid, Medicaid must deny the claim. Because it was the provider's responsibility to obtain authorization, the provider is prohibited from subsequently billing the patient for the unpaid service. Refer to Chapter 6 - 7, Medicaid as Payment in Full; Billing Patients Prohibited.

D. There are specific, limited exceptions to the requirement that approval must be obtained BEFORE service being provided. The exceptions are explained in and limited by Chapter 9 - 7, Retroactive Authorization.

9 - 1 Unspecified Services and Procedures

Unspecified services or procedures covered by Medicaid do not require prior authorization. These codes typically are five numbers ending ". . . 99". Do not use unspecified service or procedure codes to provide services which are not a Medicaid benefit. Submit documentation for these codes with the claim form for prepayment review. Documentation should include medical records, such as the operative report, patient history, physical examination report, pathology report, and discharge summary, which provide enough information to identify the procedure performed and to support medical necessity of the procedure.

9 - 2 Non-Covered Procedures

Generally, Medicaid does not reimburse non-covered procedures. However, exceptions may be considered through the prior authorization process in the circumstances listed below and when no code that is a Medicaid benefit accurately describes the service to be provided:

1. The patient is a child under 21 years of age. Because of the patient's age, the Child Health Evaluation and Care Program (CHEC) may pay for services which are medically necessary but not typically covered by Medicaid. The CHEC program is based on a preventive health philosophy of discovering and treating health problems before they become disabling and therefore more costly to treat in terms of both human and financial resources. Please refer to SECTION 2, CHEC SERVICES, for additional information. For your convenience, the PA requirements for CHEC services are listed in the Chapter 9 - 3, Prior Authorization Criteria.

2. Reconstructive procedures following disfigurement caused by trauma or medically necessary surgery.

3. Reconstructive procedures to correct serious functional impairments (for example, inability to swallow).

4. When performing the procedure is more cost effective for the Medicaid Program than other alternatives.

9 - 3 Prior Authorization Criteria

In December 1996, Medicaid staff began using the "Medical Review Criteria and System" developed by InterQual, Inc. in conjunction with locally developed prior authorization criteria. Staff were trained in the use and application of the criteria to review prior authorization requests for medical necessity and appropriateness and complete all prior authorization, utilization or post payment reviews. The locally developed criteria used to review a prior authorization request are described in SECTION 2 or listed with each procedure code requiring PA.

When a service is not ordinarily covered by Medicaid, but it is for a child under 21 years of age, Medicaid may authorize the service under the Child Health Evaluation and Care Program (CHEC). For complete information, refer to the Utah Medicaid Provider Manual for CHEC Services. Prior authorization requests for CHEC services must be in writing and include the information listed below:

1. The estimated cost for the service or item;

2. A photocopy of any durable medical equipment item(s) requested;

3. A current comprehensive evaluation of the child's condition, completed by the appropriate therapist, that includes the diagnosis, general medical history, therapy treatment history, age, height, weight, capabilities, prognosis, specific limitations, and the purpose for any durable medical equipment that is requested;

4. A letter from the physician describing medical necessity and including the diagnosis, the medical reason for the request, the medical condition that justifies the request, and the portion of the medical history that applies to the specific request. The letter must be patient specific, indicate the reasons the physician is recommending the service or equipment, and whether the service or equipment would contribute to preventing a future medical condition or hospitalization.

The physician making the request, the therapist and the provider should communicate directly and work as a team to evaluate the most appropriate services for the child.

9 - 4 Prior Authorization Procedures

Prior authorization (PA) applies to all services which require PA and which are either:

(1) Not covered by a capitated managed care plan, or

(2) In one of the following programs: Psychology, Personal Care Services, Targeted Case Management Services, and Home and Community-Based Waiver Services. Providers of these services should follow the prior authorization process in the applicable provider manual.

A. When prior authorization is required for a health care service, the provider must obtain approval from Medicaid BEFORE service is rendered to the patient. Medicaid can pay for services only if ALL conditions of coverage have been met, including but not limited to, the requirement for prior authorization.

B. A provider must complete a Request for Prior Authorization form and submit it with any required documentation to the Medicaid agency as indicated. A copy of the Request for Prior Authorization form and instructions are in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

1. Any exception to the requirement for written prior authorization is noted in SECTION 2 of this manual for specific provider types and services. A code which requires PA indicates whether the request may be made by telephone or must be in writing. For example, a telephone request for prior authorization may be permitted for certain services.

2. Generally, the provider sends a request for Prior Authorization to the Utilization Management Unit in the Division of Health Care Financing. Any exception is noted in SECTION 2 of this manual.

C. The Medicaid agency reviews the request to determine if the service is covered by Medicaid and if it meets the criteria for medical necessity, based on information given by the provider.

1. A service may be covered when it is included in either of these groups:

   a. Within one of the 21 types of service covered by the Utah State Plan for adults, or

   b. Within one of the 25 types of service listed in 42 USC 1396d(a) for children under the age of 21.

2. A service is considered medically necessary when it meets the conditions of Chapter 7, Medical Standards - Medical Necessity.

D. Medicaid sends a written notice to the provider, and a copy to the patient, advising of the request for authorization and the decision. Federal regulations (42 CFR §431.206) require Medicaid to "give notice to the patient" when any action "may affect his claim."

1. When the service is covered, but there is not enough information to determine medical necessity, a letter is sent to the provider, and a copy to the patient, requesting specific additional information. The provider must furnish the necessary documentation or information with the cooperation of the Medicaid patient.

   a. The letter states intent to deny the service because of insufficient information. It explains additional information needed. Twenty-one days are allowed for receipt of the information requested.

   b. If the requested information is not received within 21 days, the request is denied.

   c. If the request is denied solely because of insufficient documentation, and either the patient requests a hearing or the documentation is sent in, the Program Manager in the Division of Health Care Financing responsible for hearings can either process a new request for prior authorization or proceed with a hearing. The request cannot proceed simultaneously through both a hearing and the prior authorization process.

2. When Medicaid denies authorization, the letter of denial includes the following information:

   a. The action the State intends to take;

   b. The reasons for the action, including findings of fact;

   c. Statement of the laws and criteria supporting the action;

   d. The patient's right to a hearing;

   e. The process to request a hearing;

   f. The patient's right to be represented by an attorney or other person;

   g. The circumstances, if any, under which the service is continued pending the outcome of the hearing.

   Attached to the letter are a copy of the laws and criteria supporting the decision and a form and instructions for requesting a hearing.

   The denial letter does not ask for new information. Once a request is denied, the next opportunity to discuss the decision and present additional information for consideration is a prehearing conference. The only exception is explained in item D 1 c above which begins “If the request is denied solely because of insufficient documentation . .”

E. When a patient submits a request for a hearing, Medicaid follows the policy and procedure under Utah Administrative Code, Section R410.14.

9 - 5 Written Prior Authorization

Send written requests to:

MEDICAID PRIOR AUTHORIZATION UNIT
P. O. BOX 143103
SALT LAKE CITY UT 84114-3103

Prior authorization requests may also be faxed to (1-801) 538-6382, attention "Prior Authorizations"

9 - 6 Telephone Prior Authorization

When policy permits a request for authorization to be made by telephone, call Medicaid Information and follow the telephone menu prompts. Refer to Chapter 12, Medicaid Information.

Prior Authorization hours are:
Monday, Tuesday, Wednesday, and Friday . . . 8:30 a.m. - noon and 1:00 p.m. - 4:30 p.m.
Thursday . . . . . (not available in morning) 1:00 p.m. - 4:30 p.m.

9 - 7 Retroactive Authorization

Retroactive authorization is approval given after a service has been provided. Retroactive authorization may be considered ONLY in the circumstances listed in this chapter. The provider must complete a Request or Prior Authorization form and include documentation for the reason service was provided before Medicaid gave authorization.

A. **Retroactive Medicaid Eligibility**

When a client becomes eligible for Medicaid after receiving services which would have required prior authorization, Medicaid may consider a prepayment review, rather than denying reimbursement solely because prior authorization was not obtained. The provider should explain this circumstance on the Request for Prior Authorization form.

B. **Medical Supplies Provided in a Medical Emergency**

Certain medical supplies and equipment that require prior authorization may be provided in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, and an item on the list below is provided, Medicaid may consider the request for retroactive authorization and payment.

- Enteral and parenteral therapy equipment
- Enteral or parenteral nutrients
- Hospital bed and related equipment
- Oxygen and related respiratory equipment
- Gaseous oxygen or liquid oxygen only when supplied to a private client who subsequently becomes Medicaid eligible
- Humidifier/nebulizer

Only the supplies and equipment in the list above may be considered for retroactive authorization. It is the responsibility of the medical supplier to substantiate the emergency and provide the necessary documentation to support a prepayment review. Providers must obtain prior authorization for all other services, supplies, and equipment, even if the client's circumstances appear to qualify as an 'emergency."

C. **Surgical Emergency**

Surgical procedures that require prior authorization may be performed in a medical emergency before authorization is obtained from Medicaid. When a medical emergency occurs, Medicaid may consider the request for retroactive authorization and payment. To qualify, the procedure must have been performed in a life-threatening or justifiable medical emergency. An example is the procedure to terminate an ectopic pregnancy.

It is the responsibility of the surgeon to substantiate the emergency and provide all necessary documentation to support a prepayment review of the services for all providers concerned. Documentation from the medical record to support the emergent nature of the procedure includes the following:

1. Patient history and physical
2. Consent form, if applicable (hysterectomy, sterilization or abortion), completed according to instructions. Refer to SECTION 2, PHYSICIAN SERVICES.
3. Operative report
4. Pathology report
5. Discharge summary

D. Medicaid is responsible for the delay in authorization.

9 - 8 Ancillary Services

Providers who accept a patient covered by Medicaid should ensure that any ancillary services provided to the patient are delivered by a participating Medicaid provider. This includes lab, x-ray, and anesthesiology services. In addition, when the service requires prior authorization (PA) and a PA number is obtained from Medicaid, give a copy of the patient's Medicaid Identification Card or, at minimum, the Medicaid Identification number and the PA number to all providers rendering ancillary services to the patient. This will assist the other providers who may be required to submit the PA number when billing Medicaid.

10 RECORD KEEPING AND DISCLOSURE

Every provider must comply with the following rules regarding records:

1. To maintain for a minimum of five years all records necessary to document and disclose fully the extent of all services provided to Medicaid patients and billed, charged, or reported to the State under Utah's Medicaid Program;

2. To promptly disclose or furnish all information regarding any payment claimed for providing Medicaid services upon request by the State and its designees, the Fraud Control Unit, or the Secretary of the United States Department of Health and Human Services. This includes any information or records necessary to ascertain, disclose, or substantiate all actual income received or expenses incurred in providing services or during the same period as Medicaid services were provided. In addition, all providers must comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B as applicable, except for individual practitioners or groups of practitioners. (A copy of these requirements will be furnished upon request);

3. To allow for reasonable inspection and audit of financial or patient records for non-Medicaid patients to the extent necessary to verify usual and customary expenses and charges.

Upon request, the State will furnish reimbursement to the provider for the cost of making copies of records in compliance with Subsection B, at a rate not to exceed 10 cents per copy when there are 20 or more pages to be copied.

10 - 1 Government Records Access and Management Act (GRAMA)

The Utah Department of Health, Division of Health Care Financing, follows the provisions of the Government Records Access and Management Act (GRAMA) in classifying records and releasing information.
Reference: Utah Code Annotated, Title 63, Chapter 2.

10 - 2 Confidentiality of Records

In accordance with the Government Records Access and Management Act (GRAMA), Utah Code Annotated, Title 63, Chapter 2 et seq., UCA (198653), any information gained from patient records is classified as *controlled* and must be protected pursuant to the guidelines established by law in order to protect the privacy rights of the patients.

Any information received from providers is classified as *private* and will be protected pursuant to the guidelines established by law in order to protect the privacy rights of providers. Records and information acquired in the administration of any part of the Social Security Act are *confidential* and may be disclosed only under the conditions prescribed in rules and regulations of the Department of Health and Human Services, or on the express authorization of the Secretary of the Department of Health and Human Services.

A Medicaid provider may disclose records or information acquired under the Medicaid Program only when the record or information is to be used in connection with a claim or for utilization of Medicaid benefits. This disclosure may be necessary for the proper performance of the duties of an employee of the Division of Health Care Financing, or any public or private agency organization authorized under an agreement with the Utah State Department of Health, to meet the requirements of the Medicaid Program or to conduct a legal proceeding.

Any request by the patient for records disclosure must be cleared by the Division of Health Care Financing. Contact Medicaid Information. Refer to Chapter 12, Medicaid Information.

10 - 3 Access to Records

A provider who receives a request from Medicaid for access to or inspection of documents and records must promptly and reasonably comply with free access to the records and facility at reasonable times and places. A provider must not obstruct any audit or investigation, including the relevant questioning of employees of the provider.

If a provider unreasonably refuses to grant access to records, or cannot provide adequate records for reimbursed services, the services shall be deemed undocumented. The provider must refund all payments for undocumented services. The State may deduct an equal amount from future provider payments

Repeated refusal to provide or grant access to the records as described above will result in the termination of the existing Medicaid provider agreement.

10 - 4 Documentation and Signature Requirements

To support its mission to provide access to quality, cost-effective health care for eligible Utahns, the Division of Health Care Financing requires providers to meet the *Evaluation and Management Documentation Guidelines* developed jointly by the American Medical Association and the Health Care Financing Administration, effective July 1, 1998. In addition, the Division uses InterQual criteria and criteria developed internally under the guidance of the Utilization Review Committee. Documentation and signature requirements are as follows:

A. **Documentation requirements**

The General Principles of Medical Record Documentation in the *Evaluation and Management Documentation Guidelines* are listed below

1. The medical record should be complete and legible.
2. There is no specific format required for documenting the components of an E/M service.
3. The documentation of each patient encounter should include:
    a. the chief complaint and/or reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
    b. assessment, clinical impression or diagnosis;
    c. plan for care; and
    d. date and a verifiable, legible identity of the health care professional who provided the service.
3. If not specifically documented, the rationale for ordering diagnostic and other ancillary services should be able to be easily inferred.
4. To the greatest extent possible, past and present diagnoses and conditions, including those in the prenatal and intrapartum period that affect the newborn, should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified
6. The patient's progress, response to and changes in treatment, planned follow-up care and instructions, and diagnosis should be documented.
7. The CPT and ICD-9-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
8. An addendum to a medical record should be dated the day the information is added to the medical record, not the day the service was provided.
9. Timeliness: A service should be documented during, or as soon as practicable after it is provided, in order to maintain an accurate medical record.
10. The confidentiality of the medical record should be fully maintained consistent with the requirements of medical ethics and of law.

B. **Signature Requirement**

In keeping with the objectives of 42 CFR 456 Subpart B (to review and evaluate utilization, service, exceptions, quality of care, and to promote accuracy and accountability), providers and the service they provide must be clearly recognized by name and specialty. Any professional providing service and entering documentation in the patient record must include a verifiable, legible signature and professional specialty designation following all entries.

A. **Physician Responsibilities**

The physician has the major responsibility for the patient's medical record and services provided. A recognizable signature, customary to the way in which the physician identifies himself, should be found throughout the record on all direct service entries, consultations or reports.

When service to the patient is provided "incident to" or "under the supervision" of the physician and documented by non-physician personnel, the medical record entry must have sufficient documentation to show active participation of the physician in planning, supervising or reviewing the service.

The physician's signature must accompany every documented patient encounter if the service is being billed with the physician provider number.

B. **Other Professional Services**

Other professionals working in group practices, clinics or hospitals such as nurses, physical therapists, occupational therapists, dietitians, social workers, etc., providing service under a plan of care or following orders of a physician, must provide appropriate documentation, signature and professional designation following entries in the patient's medical record

C. **Accepted Alternative Signature**

Electronic signatures, by federal law, are acceptable. Record documentation made by electronic means has the same legal weight as signatures on paper.

When a service note is dictated and subsequently transcribed into the record over the typed name of the provider, legible initials of the provider next to the typed name are acceptable and imply review and agreement with the documentation.

4. **Unacceptable Signature**

A signature stamp affixed to an entry in the patient's medical record is not sufficient to assure physician review and agreement that the documentation is an adequate representation of the service. Initials alone following an entry are not appropriate, unless that is the customary way a signature is provided.

NOTE: Evaluation and Management documentation guidelines were initially developed jointly by the American Medical Association and the Health Care Financing Administration and implemented in 1995. A revised set of guidelines was issued in 1997 for use beginning in July, 1998. Some changes may be considered again, but until such time as changes are officially announced and implemented, the 1997 guidelines are accepted by Utah Medicaid and utilized by staff reviewers during the Utilization Management record review process. Any decisions made by Utah Medicaid staff while completing the required quarterly review of medical records will be based on the 1997 Evaluation and Management Documentation Guidelines issued by the Health Care Financing Administration [Name changed in June 2001 to Centers for Medicare & Medicaid Services.]

11 BILLING CLAIMS

Procedures and regulations for billing Medicaid follow. Medicaid providers should be aware of Federal regulations which limit use of business agents, prohibit the use of factors, and unacceptable billing practices.

11 - 1 Business Agents

A billing or business agent is a person or an entity that submits a claim for a provider and receives Medicaid payments on behalf of a provider. Payments may be made to a business agent, such as a billing service or an accounting firm that furnishes statements and receives payments in the name of a provider, if the agent's compensation for this service meets three conditions:

1. Is related to the cost of processing the claim;

2. Is not related on a percentage or other basis to the amount that is billed or collected; and

3. Is not dependent upon the collection of payment.

Reference: 42 CFR §447.10(f)

11 - 2 Factoring Prohibited

As a reminder to all providers, Federal Regulations prohibit the use of a factor to obtain payment from Medicaid for any service furnished to a Medicaid patient. The regulations define a factor as an individual or an organization, such as a collection agency or service bureau, which advances money to a provider for accounts receivable that the provider has assigned, sold, or transferred to the individual organization for an added fee or a deduction of a portion of the accounts receivable. A factor does not include a business representative. Reference: 42 Code of Federal Regulations §447-1(b).

Payment for any service furnished to a Medicaid patient by a provider may not be made to or through a factor, either directly or by power of attorney. Reference: 42 Code of Federal Regulations §447.10(h).

11 - 3 Unacceptable Billing Practices

The use of any device or strategy that may have the effect of increasing the total amount claimed or paid for any service beyond the maximum allowable amount payable for such service is not allowed. Following are examples of unacceptable billing practices.

A. Duplicate billing or billing for services not provided, overstating or mis-describing services, and similar devices;

B. Submitting claims for services or procedures that are components of a global procedure;

C. Submitting claims under an individual practitioner's provider number for services performed by the practitioner as an employee of or on behalf of a group practice or clinic when the service has been billed under the group or clinic number;

D. Use of more intensive procedure code than the medical record indicates or supports.

11 - 4 Billing Third Parties

Before submitting a claim to Medicaid, collect ONLY the applicable Medicaid co-payment usually charged at the time of service. The provider should include the primary Insurance co-pay as part of the submitted charges to Medicaid. A provider must explore payment from all other liable third parties such as insurance coverage, a health maintenance organization and Medicare Part A and B, if applicable. The provider must submit and secure payment from all other liable parties before seeking Medicaid payment. The Medicaid payment is made after all other liable third parties have made payment or sent a denial.

A. If the client has Medicare A & B as Primary Insurance and also has Medicaid, the provider should collect the applicable Medicaid co-payment.

B. If the client has Qualified Medicare Benefits (QMB), or QMB with Medicaid, do not collect the Medicaid co-pay amounts EXCEPT the co-pay and co-insurance for pharmacy services and non-emergency use of the emergency room.

C. Bill the responsible third party, then Medicaid, as follows:

1. Submit the claim to the third party or parties.

2. If the third party pays the claim, submit a claim to Medicaid and show the TPL payment according to instructions. Medicaid bases any subsequent reimbursement on the Medicaid fee schedule.

   a. Medicaid will not make an additional payment if the amount received from the insurance company is equal to or greater than the Medicaid reimbursement amount. In this case, the TPL payment is considered payment in full. A provider will not bill the patient for any difference between the amount charged and the TPL payment received.

   b. If a provider receives a third party payment and does not bill Medicaid for the balance because he or she anticipates the Medicaid payment to be zero, the TPL payment is considered payment in full, and the provider will not bill the patient.

   c. Medicaid will make an additional payment to a provider for services rendered if the payment received from the insurance company is less than the Medicaid reimbursement amount.

   d. An exception is inpatient hospital claims with third party insurance. Refer to SECTION 2 of the Utah Medicaid Provider Manual for Hospital Services, Chapter 5 - 1, Inpatient Hospital Claims with Third Party Insurance.

3. If the third party denies the claim for any reason (non-covered benefit, patient not eligible, etc.) submit a claim to Medicaid. Indicate there is an attachment to the claim. The claim may be filed electronically, and written documentation on the TPL response can be sent separately.

   Send a copy of the denial from the responsible third party if the denial was written. If the denial was given verbally, include the name of the person who said the claim was denied, the date of the denial, and the reason for the denial.

   a. If the TPL information appears to be incorrect, please advise the patient to call the TPL unit in the Office of Recovery Services at the Department of Human Services. The telephone number is printed on the bottom of the Medicaid Identification Card.

   b. Providers may also call the Office of Recovery Services to advise them of correct third party liability information. Telephone numbers are listed in Chapter 5 - 5, Third Party Liability.

4. If the third party pays less than reported on the Medicaid claim, submit a Payment Adjustment Request showing the amount received from the TPL.

5. When a Medicaid claim is suspended for third party liability information, you can expedite the processing of the claim by FAXing the complete Explanation of Benefits (EOB) directly to the Health Claims team in the Office of Recovery Services. Include the second page which usually has the definitions of coded reasons for not paying the claim. Use FAX number **(801) 536-8513.**

   You do not need to send the EOB to Medicaid Claims Processing. Any EOB's received by Medicaid are forwarded to the Office of Recovery Services.

11 - 5 Billing Services for Newborns

Bill all services for newborns with the baby's own (unique) Medicaid Identification number. The baby's identification number can be found on the mother's Medicaid Identification Card, often with the name "Unborn" and the expected date of birth. You may also obtain the baby's Medicaid number by calling Medicaid Information. Refer to Chapter 12, Medicaid Information.

If the baby does not have a unique Medicaid Identification number, the mother must notify her Medicaid eligibility worker immediately. The worker determines the child's eligibility, and a unique Medicaid Identification number is assigned to the child.

NOTE: A newborn infant is NOT covered when his or her mother is eligible only for the Baby Your Baby Program. In this case, the mother must apply for Medicaid on behalf of the child if she needs assistance in paying the child's medical bills.

11 - 6 Medicare/Medicaid Crossover Claims

A Crossover Claim is a coordination of benefit claim for a recipient who has both Medicare and Medicaid eligibility. If the provider accepts assignment for Medicare Part A or Part B, the Crossover claim is sent to Medicaid Crossovers automatically from the intermediary. If the provider does not accept assignment, a claim is not sent automatically, and the provider must submit the claim directly to Medicaid Crossovers.

There are two exceptions:

1. Inpatient claim, Part B only. After Medicare pays the claim, it is processed as a Medicaid claim with the Medicare payment on the claim. Medicaid then pays the hospital charges.

2. Out of plan claims, with the Medicaid Insurance Payment Report Form (IPR) attached.

Payment is reported on the Crossover section of the Medicaid Remittance Statement. The Medicare and Medicaid payment is considered payment in full.

11 - 7 Filing Crossover Claims

Submit claim and a Medicaid Insurance Payment Report Form (IPR) directly to Medicaid Crossovers. The form and instructions are in the General Attachments Section of the Medicaid Provider Manual or on-line at http://health.utah.gov/medicaid. An IPR must be submitted with the claim regardless of the payment amount.

To ensure prompt processing, the Medicaid provider number must be on the claim. The deadline for filing a Crossover claim is six (6) months from the date of the Medicare payment.

PAPER CLAIMS

Submit to:
Medicaid Crossovers
P.O. Box 143106
Salt Lake City, Utah 84114-3106

ELECTRONIC CLAIMS
It is not necessary to submit an EOMB for $0 payment or denials. Complete the other payer payment information, including payer paid amount, patient liability and reason codes.

Submit to:
HT000004-005 Utah Medicaid Crossovers

11 - 8 Non-Covered Medicare Services

Bill claims for non-covered Medicare services, such as non-durable medical supplies, drugs, and ICF nursing home care provided to Medicare/Medicaid eligible patients directly to Medicaid.

11 - 9 Billing Medicaid

Medicaid accepts claims submitted in one of two ways:

- Standardized claims submitted through an electronic data exchange;
- On appropriate paper claim forms.

Standards for the HCFA-1500 Claim Form are available from the insurance commissioner and through the Utah Health Information Network (UHIN) web site: **www.uhin.com/uhin**. UHIN also provides the software required to bill electronically. Therefore, the Utah Medicaid agency no longer provides payer specific billing instructions for the HCFA-1500 Claim Form.

1. Electronic Data Exchange: UHIN

Electronic data exchange means a provider sends and receives claim-related information electronically. The *Utah Health Information Network or "UHIN" is an electronic network to centralize transactions for providers and payers, including Medicaid. Providers who use UHIN can send claims to one point instead of sending claims to each third party payer.

Providers interested in electronic submission of claims must contact UHIN at 801-466 -7705 and obtain certification to submit through the UHIN platform. Visit UHIN's website at www.UHIN.com. As of October 2003, electronic features include:

- submission acknowledgment with the status of each claim submitted, whether rejected or accepted.
- remittance advice to allow a 'download' of payment information directly to a practice management system. It also allows automatic payment posting for accounts receivable.

- eligibility inquiry and response
- claim status and response
- prior authorization

As electronic data interchange features become available, Medicaid will notify providers in the Medicaid Information Bulletin.

*In Utah, a coalition of insurers, providers, the Utah Medical Association, the Utah Hospital Association, and State Government developed the Utah Health Information Network or "UHIN".

ANSI Standards Requirements
Providers who are considering adding computer software support for submitting claims, reporting third party liability, and reporting encounter records data should make sure that the software conforms with ANSI standards for the electronic transmission of health information. As a member of UHIN, Medicaid supports the development of national standards and requires the use of the national ANSI standards for receiving and returning electronic information. Utah is acting in accordance with the requirements of HR 3103, the Health Coverage Availability and Affordability Act of 1996. This act is also referred to as the Insurance Portability Act and as the Kennedy-Kassebaum Act, named after the two senators who sponsored the bill. Title II of HR 3103, Subpart F, Administrative Simplification, is intended to improve the efficiency and effectiveness of the nation's health care system. The establishment of standards and requirements for the electronic transmission of certain health information is an important step to accomplish this goal.

Your software vendor can advise you as to systems which use the ANSI standards in compliance with HR 3103 and the UHIN requirements.

Approved Software: *UHINT and ProClaim*
Two software packages are approved for electronic submission of claims.

UHINT is a new baseline translator product (Utah Health Information Network Transactor) which is able to file CMS-1500 claims, UB92 claims, dental claims and other HIPAA transactions. UHINT utilizes an Internet-based solution for transmission of transactions. For more information visit the UHIN website at http://www.uhin.com/new_products.htm .

The Proclaim/Acclaim software, which was two different software packages, have been combined into one software package which will continue to be called Proclaim. This software meets all requirements for submission of professional and institutional claims and other HIPAA transactions. Proclaim is a dial-up method of data communications operating in a Windows environment. For more information regarding Proclaim software products, call the switch help line: (801)333-2900.

Other Acceptable Software
Acceptable software must meet all file and data specifications contained in the ANSI X12 Medicare implementation standard.

Trading partners, whether individual providers or provider groups, have responsibilities to adequately test all business rules appropriate to their type and specialty. If using a third-party vendor (clearinghouse), it is the obligation of the trading partner to ensure the vendor has adequately tested all business rules appropriate to each provider type and specialty.

Point of Sale (POS) system
The Point of Sale (POS) system accepts standardized claims for pharmacy services to be submitted through an electronic data exchange. For information about acceptable software for submitting inquiries, transmitting claims, and electronic procedures and messages, refer to SECTION 2, PHARMACY SERVICES.

2. Paper Claims

Medicaid accepts appropriate paper claims, such as the HCFA 1500 dated 12-90, UB-92 Hospital Claim, ADA Medicaid accepts appropriate paper claims, such as the CMS 1500 dated 12-90, UB-92 Hospital Claim, ADA Dental Claim (version 1999 or 2002), NCPDP Pharmacy Claim. (Effective April 1, 1997, the HCFA-1500 claim form dated 1-84 is no longer accepted.) Providers who use the paper claim form may visit the Utah Health Information Network (UHIN) website for standard instructions at www.UHIN.com .

11 - 10 Time Limit to Submit Medicaid Claims

Payment for services will be made only if claims are submitted to Medicaid within one year from the date of service. Any exception to the one-year limit is stated in SECTION 2 for the type of service provided.

Payment will be made for Medicare/Medicaid Crossover claims only if claims are submitted within six months from the date of Medicare payment stated on the Medicare Explanation of Medical Benefits (EOMB).

References: Code of Federal Regulations 42 (CFR), Section 447.45(d) (1). Utah Administrative Code, Rule R414-25x.

11 - 11 Rebill Denied Claims with Corrected Information

If a claim has been denied for incorrect information, correct the claim and resubmit it, rather than calling Medicaid Information. Until the claim is billed correctly, it cannot be processed.

11 - 12 Denial of Payment for Patients Not Eligible for Medicaid or Enrolled in a Managed Care Plan

Medicaid is a benefit only to eligible persons. Medicaid will not pay for services rendered to a client who is not eligible for Medicaid benefits on the date the service is rendered, nor will Medicaid pay for services covered by a managed care plan, such as an HMO or Prepaid Mental Health Plan, in which the patient is enrolled. Because Medicaid makes available information as to what medical or mental health plans the patient must use, a fee for service claim will not be paid even when information was given in error by Medicaid staff. Staff make every effort to provide complete and accurate information on all inquiries.

11 - 13 Requesting Review of Claim That Exceeds Billing Deadline

It is to your advantage to submit claims and follow-up on unpaid balances quickly. Claims received by Medicaid after the billing deadline will be denied. Very few exceptions can be made. Generally, the billing deadline is one year of the date of service. Any exception to the one-year limit is stated in SECTION 2 for the type of service provided. (Reference: Chapter 11 - 10, Time Limit to Submit Medicaid Claims)

When Payment Can Be Made on 'Late' Claims

If Medicaid denied a claim for exceeding the billing deadline, and you think we should pay the claim, you may request a review for payment. The situations listed below may be considered for review, provided specific, appropriate documentation is submitted.

1. Proof of Timely Filing
   a. You have a Utah Medicaid Remittance Statement or original TCN showing that we received the original claim within the billing deadline.
   b. You have specific business records prepared at the time the claim was first submitted, and the records show the claim was filed within the billing deadline.

2. Medicaid client received retroactive eligibility
   You have Medicaid eligibility verification to show that a client received retroactive eligibility, and the TCN on the denied claim is within the billing deadline based on the date eligibility was determined for the client.

3. HMO billed in error
   You billed an HMO in error and have a denial from the HMO showing it received the claim within the billing deadline.

4. Court order or hearing decision
   You have a court order or hearing decision which caused the claim to be submitted after the billing deadline.

Requesting Review For Payment

If you have documentation to prove one of the situations stated, complete a Payment Adjustment Request Form according to instructions. Do not submit a new claim. A copy of the form is in the General Attachments Section of your Utah Medicaid Provider Manual. You may also print a copy from the World Wide web at http://health.utah.gov/medicaid/pdfs/PAR.pdf

When the form and documentation are received, your request will be reviewed. Medicaid will either waive the time limit, process the claim, and make payment OR send a denial with a copy of your hearing rights.

12 MEDICAID INFORMATION

Telephone

In the Salt Lake City area, call Medicaid Information: **538-6155**
In Utah, Idaho, Wyoming, Colorado, New Mexico, Arizona, and Nevada, call toll-free **1-800-662-9651**
From other states, call **1-801-538-6155**

Medicaid Information has a telephone menu to reduce waiting time and the number of transfers for Medicaid providers and clients. A flowchart of the **Medicaid Information Line** menu is included in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual. Customer Service Representatives are available:

Monday, Tuesday, Wednesday and Friday . . 8:00 a.m. to noon and 1:00 p.m. to 5:00 p.m.
Thursday . . . . . 11:00 a.m. - noon and 1:00 p.m. to 5:00 p.m.

FAX Numbers

Each Medicaid team has its own FAX line in order to provide better customer service. These FAX numbers are on the back of the ACCESSNOW instructions in the GENERAL ATTACHMENTS Section of this manual.

Mailing Address for Medicaid Claims

BUREAU OF MEDICAID OPERATIONS
BOX 143106
SALT LAKE CITY UT 84114-3106

NOTE: All Medicaid paper claims must be sent via the U.S. Postal Service.

Street Address

Department of Health
288 North 1460 West
Salt Lake City, Utah

NOTE: The Department of Health (the Martha Hughes Cannon Building) is a secure building. Public access is restricted to the lobby area, cafeteria, Vital Records, and a designated conference room, all located on the first floor. Access to other areas of the building requires an employee escort. State and Federal privacy laws do not permit staff at the Martha Hughes Cannon Building's information desk, or any other reception desk in the building, to handle Medicaid claims.

Automated Medicaid Information System: ACCESSNOW

ACCESSNOW, the touch tone telephone eligibility line, is a free information system for Medicaid providers. ACCESSNOW allows you to access information directly and at your convenience.

ACCESSNOW is operated with the use of a touch tone telephone. It provides the following information: client eligibility, including client restrictions, other insurance coverage, HMO enrollment, and primary care physician information where applicable. In the GENERAL ATTACHMENTS section of this manual, there is a step-by-step guide for use of ACCESSNOW. You need a touch tone phone, your 12-digit Medicaid provider number, and the client's Medicaid Identification Number OR the client's Social Security Number and Date of Birth.

AccessNow is available Monday through Saturday from 6:00 a.m. to midnight and Sunday from noon to midnight. There is no limitation on the number of inquiries you can make. Call Medicaid Information and follow the menu instructions to reach ACCESSNOW.

*

Electronic Mail Access to Medicaid Staff

Electronic mail (e-mail) messages may be sent to Medicaid staff (employees of the Division of Health Care Financing, Department of Health) through an Internet provider. All staff - Customer Service Representatives, provider enrollment, pharmacy and transportation team members, publications, policy staff, etc. - have an e-mail address. If you wish to ask a question, provide information needed to process a claim or a prior approval request, request publications (Provider Manuals, Medicaid Information Bulletins, and Amber Sheets), you may send an e-mail as an alternative to a telephone call or FAX. Ask the person to whom you wish to send a message for his or her e-mail address.

12 - 1 Internet Site

The Division of Health Care Financing, Department of Health, has two Internet sites with information for Medicaid providers: Medicaid-specific information: **http://health.utah.gov/medicaid**
HIPAA: **http://health.utah.gov/hipaa/**

Medicaid-specific web site:

There are six selections on the Medicaid home page:

- **Medicaid A - Z**. This web page has a quick reference, alphabetical index linking to subjects and keywords in the Medicaid web site.
- **Programs**. This web page provides general information about the Utah Medicaid Program and eligibility criteria such as income and resource limits
- **Provider**. This web page has links to the on-line Utah Medicaid Provider Manual, Bulletins and other information for Medicaid providers
- **Client**. This web page has links to publications, brochures and newsletter with information for Medicaid clients.
- **Questions**? This web page has information on contacting Medicaid, the client advocate, and a local Medicaid office.
- **Espagñol**. This links to language and interpretive services. Spanish is the most commonly requested; services for many other languages are also offered.

HIPAA web site:

This web site contains Utah specific information relating to federal standards imposed on electronic data interchange (EDI) by implementation of the Health Insurance Portability and Accountability Act (HIPAA). Provider links to Utah specific billing instructions (companion guides), privacy notices, EDI enrollment information, crosswalk of Utah Local Codes, etc., are provided.

12 - 2 Information for Clients

Medicaid clients receive information as to the proper and appropriate use of the Medicaid services and benefits covered in several ways. Information sources include Medicaid eligibility staff; face-to-face and group education; pamphlets, brochures, and newsletters; Medicaid Information; and the client Information Internet site at:
http://health.utah.gov/medicaid/provhtml/clients.htm

13 OTHER MEDICAL ASSISTANCE PROGRAMS

The Department of Health administers or pays claims for medical assistance programs other than the Utah Medicaid Program. Other programs include Presumptive Eligibility (Baby Your Baby), Primary Care Network (PCN), Custody Medical Care, Qualified Medicare Beneficiary, and Emergency Services For Non-Citizens. These programs, eligibility verification and covered services are described in the chapters which follow.

13 - 1 Presumptive Eligibility Program (Baby Your Baby)

The Presumptive Eligibility Program, also known as the Baby Your Baby Program, covers outpatient, pregnancy-related, prenatal care for eligible pregnant women prior to establishing eligibility for Medicaid. Pregnant women apply for this program with a qualified health provider, usually through a community health center or public health department.

Verification
A woman eligible for a Baby Your Baby Identification Card must present the card each time she requests prenatal services. A copy of this card is included with the sample Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual. ALWAYS CHECK ELIGIBILITY DATES on the Baby Your Baby Card! The card has an initial expiration date pending a formal decision of eligibility for Medicaid.

The Medicaid eligibility verification systems, ACCESSNOW, Medicaid On-Line and Pharmacy Point of Sale, indicate whether the client's number ends in a 'V'. The 'V' means the provider must VERIFY dates of eligibility on the Baby Your Baby Card. The provider may wish to copy the card to substantiate the claim for services.

When the card expires, Medicaid will no longer pay claims, unless the client has since been issued a Medicaid Identification Card for the month of service. If the woman is determined eligible for Medicaid, she receives a Medicaid Identification Card. If she is not eligible, the Baby Your Baby card is no longer valid as of the date of the formal Medicaid denial. If Medicaid eligibility cannot be determined before the Baby Your Baby card expires, the Medicaid eligibility worker may extend the expiration date.

Note: The name and phone number of the patient's Perinatal Care Coordinator are listed on the back of the Baby Your Baby Card in the lower right-hand corner.

Services Covered
Only outpatient, pregnancy-related medical services are covered. The Baby Your Baby program does NOT cover inpatient care for the woman, and it does NOT cover charges for services for a newborn infant. The mother may apply for Medicaid on behalf of the child if she needs assistance in paying the child's medical bills. NEVER collect a co-payment from a client eligible for the Baby Your Baby Program on the date of service. A co-payment will NOT be assessed by Medicaid.

Enhanced services may be covered with a referral by the patient's Perinatal Care Coordinator. The coordinator's name and phone number are listed on the back of the patient's "Baby Your Baby" card in the lower right-hand corner. If the patient has only the Medicaid Identification Card, ask her if she ever had the Baby Your Baby card and at what clinic she obtained the card. Then call the Community Health Center or local Public Health Department and ask for the perinatal care coordinator.

For more information about application, eligibility, perinatal care coordination and covered or non-covered services under the Presumptive Eligibility (Baby Your Baby) Program, call the Baby Your Baby Hotline, **1-800-826-9662**.

13 - 2 Utah Medical Assistance Program

The Utah Medical Assistance Program (UMAP) was discontinued June 30, 2002. For information about the discontinued program, refer to http://health.utah.gov/medicaid/provhtml/umap.html

13 - 3 Custody Medical Care Program

The Custody Medical Care Program pays medical bills for a child who is placed in the custody of the State and who has not yet been determined eligible for Medicaid or is not eligible for Medicaid. The program may pay for services not covered by Medicaid and for services from a provider who may not be a current Medicaid provider.

Verification

Medical services are authorized on Form MI-706, STATE MEDICAL SERVICES, by the assigned case manager in the Division of Child and Family Services. The case manager gives the foster parent this form, and it must be presented at the time of the medical visit. A copy of the form and instructions are included with the sample Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Services Covered

Only services identified on the MI-706 form are payable. Every service must be individually authorized before payment is made. Services provided without authorization will **not** be paid by the Division of Child and Family Services nor by Medicaid. Emergency services can be authorized after the fact, as long as the service is within the scope of service of the program, and Form MI-706 is obtained before billing. Services must be billed within twelve months of the date of service or six months of the date Form MI-706 was issued, whichever is later. To bill claims, follow the same instructions as for billing Medicaid claims with one exception: every claim requires a prior approval number. (The prior approval number is the MI-706 number.) Medicaid processes the claim, and the payment method and amount is the same as that for the Medicaid Program, even though the child is not eligible for Medicaid.

For more information, contact Medicaid Information. Refer to Chapter 12. You may also call Julie Thomas at (801) 538-6085. Toll-free, call 1-800-662-9651 and enter #210. The FAX number is 801-538-9428.

13 - 4 Children in State Custody (Foster Care)

Medical services for most children placed in state custody (Foster Care) are covered either by Medicaid or the Custody Medical Care Program. The State pays medical bills only when the child is eligible for either of these programs. The State does not automatically pay medical bills for children in Foster Care. BEFORE providing services, determine the child's health care coverage. Find out if the child is eligible for Medicaid and assigned to a Primary Care Provider or managed care plan.

The information in this chapter is intended to assist providers in determining and providing health coverage for a child in state custody. Please provide services to these children within the time frames outlined in the third section of this chapter, Time Frame for Services. The Division of Child and Family Services contracts with the Department of Health to provide health care case management for children in foster care. You may contact the Fostering Health Children Program with questions about serving children in state custody.

Children in Foster Care Eligible for Medicaid

BEFORE providing services, check (1) Medicaid eligibility and (2) the health care providers identified on the current Medicaid Identification Card. Services will not be reimbursed when the child is not eligible for Medicaid, nor when the child is covered by an HMO or Prepaid Mental Health Plan and the provider is not affiliated with the plan. To check eligibility and provider assignment, use the Medicaid Identification Card or Medicaid On-Line, or call ACCESSNOW.

Many of the children placed in state custody are already eligible for Medicaid and enrolled in a managed care plan, such as an HMO. As with any other enrollee, these children are covered ONLY for services received from providers affiliated with the managed care plan(s) identified. The provider receives payment from the child's managed care plan. If a child is taken to a provider who is not affiliated with the child's plan, referred to as 'out of plan', services will not be reimbursed by the plan nor by Medicaid.

The child may be enrolled in a Prepaid Mental Health Plan (PMHP) for inpatient psychiatric services only. The Medicaid Card specifies the name of the PMHP. (Foster care children may obtain outpatient mental health services from any participating Medicaid provider.) The caseworkers in the Division of Child and Family Services are responsible for coordinating any needed outpatient or inpatient mental health services.

For new enrollees, the Division of Child and Family Services (DCFS) chooses a managed care plan which contracts with the provider(s) the child has seen in the past. Foster parents and Division staff continue to be trained to use providers affiliated with the HMO and PMHP plans in which the child is enrolled.

When the child is eligible on the date of service and not assigned to an HMO nor a PMHP, services may be billed directly to Medicaid as fee-for-service. Some children in state custody come from outside the Wasatch Front (Weber, Davis, Salt Lake, and Utah counties) for medical treatment and are not enrolled in an HMO. Also, when the child is placed in a different household, a new Medicaid Identification Card must be issued. In a very few cases, this change means the child's Medicaid Card does not indicate an HMO for the first month. The provider will receive payment for services either from the child's health maintenance organization (HMO) if the child is enrolled in an HMO or from Medicaid.

When the child is not enrolled in a plan, Medicaid reimburses the provider directly. Payment for services to these children is on a fee-for-service basis.

Children in Foster Care Not Eligible for Medicaid

When a foster child is not eligible or not yet eligible for Medicaid, the child may qualify for the Custody Medical Care Program. A nurse from the *Fostering Healthy Children Program (FHC) may authorize medical services on Form MI-706, STATE MEDICAL SERVICES and give it to the foster parent. This form must be presented at the time of the visit. Services provided without this authorization will not be paid by DCFS or Medicaid. Also refer to Chapter 13 - 4, Children in State Custody.
*Fostering Healthy Children is a program within the Department of Health which contracts with the Division of Community and Family Health Services, Bureau of Children with Special Health Care Needs, to provide nurse case manager services.

Time Frame for Services

Children removed from their homes must receive certain services within the specific time frames listed below. Providers are encouraged to do everything possible to provide service to the child placed in state custody within these time frames stated.

1. Children must receive an initial physical exam within five days of removal.

2. Children must have a complete CHEC exam within 30 days of removal.

3. Children must receive a mental health assessment within 30 days of removal.

4. Children must receive a dental exam within 60 days of removal.

13 - 5 Child Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) is a medical assistance program for children who do not have other health insurance and who meet the eligibility criteria. A child may qualify when three conditions are met:

1. The child is 18 years or younger

2. Family income is below 200% of the federal poverty level (FPL) and the child is not eligible for Medicaid. The FPL is available on the Internet at http://aspe.hhs.gov/poverty/poverty.htm.
   (The Medicaid income standard is 133% FPL for ages 0-5 and 100% FPL for ages 6 - 18.)

3. There is no other insurance plan available, either from employer or individual.

For more information about the CHIP Program, call the CHIP Hotline: **1 - 888 - 222 - 2542.**
The CHIP Internet site is **http://health.utah.gov/chip** .

The CHIP Program does not have a premium payment. Refer to the sub-section below titled **Services Covered** for a description of other charges.

Providers enrolled as Medicaid providers are eligible to provide CHIP services. Billing forms, formats, codes, and the billing address are similar or identical to Medicaid's. Services are funded with a $5 to $1 match from the federal government. Funding is in part from an increase in the national cigarette tax and a Utah state hospital assessment.

Verification

Eligible clients have a CHIP identification card. Providers may also verify eligibility through the Medicaid information system. Refer to Chapter 5, Verifying Medicaid Eligibility.

Services Covered

Preventive care includes: routine physicals, well baby and well child care, immunizations, vision screening, hearing screening, and basic dental services (cleaning, exam, and x- rays). Preventive services are free. Other benefits include inpatient and outpatient hospital services, physicians' services, office visits, laboratory services, prescription drugs, mental health services, and single surface dental fillings. There are co-payments and deductibles for non-preventative care services. The amount is nominal for families with income under 150% of the federal poverty level and higher for families with income between 150% and 200% of the FPL. (The FPL is available on the Internet at http://aspe.hhs.gov/poverty/poverty.htm.)

13 - 6 Qualified Medicare Beneficiary Program (QMB)

The Qualified Medicare Beneficiary Program helps with the cost of the Medicare Program. The QMB program is not a Medicaid program. To qualify, an individual must be entitled to Medicare, have limited financial resources and low income. Refer also to Chapters 11 - 6, Medicare/Medicaid Crossover Claims, and 11 - 7, Filing Crossover Claims, for information on billing claims.

Verification

Qualified persons receive a Qualified Medicare Beneficiary (QMB) Identification Card. A copy of this card is included with the sample Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Services Covered

For people who qualify, the State pays the Medicare premiums (Part A and Part B) and the lessor of either:

a. Medicare deductibles (Part A and Part B) OR

b. The coinsurance (co-payment) for covered services under Medicare Part A and Part B, up to the amount allowed for reimbursement by Medicaid.

13 - 7 Administrative Physicals

When an administrative physical is required to determine Medicaid eligibility based on the applicant's ability to work, the Medicaid eligibility worker will give the applicant two forms. The two forms are the administrative physical form (Form 20 or Form 20M) and a reimbursement agreement, Form MI-706, Request for Medical Information. The applicant is told to take both forms to a provider who will accept the State's payment for the physical. A copy of the Form MI-706 and form instructions are included with the examples of Medicaid Identification Cards in the GENERAL ATTACHMENTS section of the Utah Medicaid Provider Manual.

Administrative physicals are used to determine eligibility for programs other than Medicaid. Providers may receive medical reports and billing forms other than the Form MI-706, Request for Medical Information. Please follow the directions for completing the forms and submitting the bill to the appropriate agency.

13 - 8 Emergency Services Program For Non-Citizens

The Emergency Services Program is a health program designed to cover a limited scope of services for a specific, defined group of individuals.

Authority

The Social Security Act Section 1903(v)(1) and 42 CFR 440.255(c) provides that no payment can be made to the state for medical assistance furnished to an alien who is not lawfully admitted for permanent residence status in the United States. People who meet all Medicaid eligibility requirements except citizenship can receive services only for an "emergency medical condition". The act defines "emergency medical condition" (including emergency labor and delivery) as "manifesting itself by sudden onset of acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in –

(A) placing the patient's health in serious jeopardy,
(B) serious impairment to bodily functions, or
(C) serious dysfunction of any bodily organ or part."

Such care and service cannot be related to an organ transplant procedure. (Emphasis added)

Definitions

The following is the Utah Medicaid definition of "emergency" as it applies to these services:

"Emergency shall mean a medical condition for which the absence of immediate medical attention could reasonably be expected to result in death or permanent disability to the person, or in the case of a pregnant woman, to the unborn child. Emergency services shall be those rendered from the moment of onset of the emergency condition, to the time the person's condition is stabilized at an appropriate medical facility, or death results. The definition of emergency services shall include labor and delivery services, but not pre-natal or post-partum services. Emergency services shall not include prolonged medical support, medical equipment, or prescribed drugs which are required beyond the point at which the emergency condition has been resolved. Emergency services also shall not include long term care or organ transplants.

Medical Identification Card

Individuals who qualify only for Emergency Services have a special card issued by Medicaid which states "EMERGENCY SERVICES". The client is eligible only for the restricted scope of emergency service defined by the Social Security Act and Medicaid's definition of emergency as noted above. These services are covered only until the condition is stabilized. A condition is stabilized when the severity of illness and the intensity of service is such that the patient can leave the facility. Services rendered subsequent to the patient leaving the facility, such as follow-up visits, follow-up treatment or visits scheduled in the future, are not covered by this program.

Documentation

Only labor and delivery services are paid for the Emergency Services client without documentation and review. Pre-natal and post-partum services ARE NOT covered for a non-citizen. Physicians and certified nurse midwives may use only the non-global delivery codes specified in SECTION 2 of the Utah Medicaid Provider Manual for Physician Services and for Certified Nurse Midwife Services.

All other services provided to a non-citizen, eligible only for the Emergency Services Program, require documentation and review before payment to determine that the services meet the definition and limitations of an emergency medical condition as outlined in the Social Security Act and 42 CFR 440.255(c).

Advising Client of Non-Covered Services

Because the Emergency Services Program has a very restricted scope of services, it does not have some of the same restrictions on billing the patient as is the case in Medicaid covered services. If a provider does not receive payment because the provider failed to follow procedure to get a service covered, the provider is prohibited from pursuing payment from the patient. If, however, payment is not made because the service was not an emergency, or the service is not provided under the program, then the patient can be billed for those services.

When a service to be rendered to an Emergency Services client is not or does not appear to be emergent in nature, the provider would be prudent to inform the patient, prior to the service, that the service will not be covered by Medicaid, and that the patient will be financially responsible for paying the bill. However, if the service meets the Medicaid definition of "emergency", Medicaid will pay for the service.

Criteria to Identify An Emergency Service

For services to be covered under the Emergency Services program, ALL of the following criteria must be present:

1. The condition manifests itself by **sudden onset**.

2. The condition manifests itself by **acute symptoms (including severe pain)**.

3. The condition requires **immediate medical attention**.

   A. Immediate medical attention means provision of service within **24 hours of the onset of symptoms or within 24 hours of diagnosis** (whichever is earlier).

   B. The condition requires acute care, and is **not chronic**.

   C. Coverage will only be allowed **until the condition is stabilized** sufficiently so that the patient can leave the acute care facility or no longer needs constant attention from a medical professional.

   D. The condition is **not related to an organ transplant procedure**.

Services provided during the prenatal or post-partum period are **not covered** unless the specific criteria listed above are met.

Steps to Seeking Payment for Services Provided to an Emergency Services Client

1. Provider submits a claim to Medicaid.

2. Medicaid pays a claim for labor and delivery for a qualified client. A claim for all other services will deny. A remittance advice will be sent to the provider.

3. When the remittance advice is received stating payment was denied, FAX or mail to Medicaid a copy of the remittance advice, the medical record **specific to the case in question,** including reports and consultations, and any other documentation in support of the services as a medical emergency. DO NOT rebill the claim.
   The FAX number for the Emergency Services Program: (801) 536-0475
   The Medicaid billing address is in Chapter 12, Medicaid Information.
   All information to be considered for review MUST be included in this initial submission.

4. Medicaid staff will review the submitted documentation. If services meet the definitions of " emergency medical condition" and "immediate medical attention" and are approved as an emergency, the claim will be reprocessed and paid. A second remittance advice will be sent to confirm payment. If criteria are not met, a letter will be sent from the Utilization Management Unit outlining the reasons for denial. Administrative Review and Fair Hearing rights will be explained in the denial letter.

5. A provider who does not agree with Medicaid's decision should refer to SECTION 1 of the Utah Medicaid Provider Manual, Chapter 6 - 15, Administrative Review/Fair Hearing.

6. Any payment made by the Medicaid Agency for a service is considered payment in full. Once that payment has been made to the provider, no additional reimbursement can be requested from the client.

13 - 9 Non-Traditional Medicaid Plan

The Non-Traditional Medicaid Plan (NTMP) provides a scope of service similar to that currently covered by the Medicaid State Plan, but with some additional limitations and reduced benefits. Eligible clients are adults over the age of 19, with children, who receive cash assistance from the Utah Family Employment Program (FEP), or they are transitioning into the workforce and eligible to receive medical assistance during the transition, or they qualify as medically needy.

Verification
Qualified persons receive a blue Non-Traditional Medicaid Plan Identification Card.

Services Covered

As stated, the scope of service is similar to the Medicaid program, but with some limitations. There are limits or benefit reductions in the following types of services: pharmacy, dental services, vision services, mental health services, substance abuse services, physical therapy, occupational therapy, chiropractic services, organ transplants, transportation services, outside medical services in free standing surgical center, emergency center (instacare type), or birthing center if chosen by the plan administrators.

For more information, refer to the SECTION titled "Non-Traditional Medicaid Plan" in selected Medicaid Provider Manuals, or use the on-line version (link at www.health.state.ut.us/medicaid/html/provider.html).

13 - 10 Primary Care Network Program

The Primary Care Network serves individuals age 19 and above with incomes under 150% of the federal poverty level who are not otherwise eligible for Medicaid through the State Plan and who are eligible only through the Demonstration Waiver.

Verification

Qualified persons receive a yellow Primary Care Network Identification Card.

Services Covered

The Scope of Service is limited to basic medical service of a general nature to provide preventive and palliative care in an outpatient, office setting. The following types of services are covered with limitations: Hospital services, physician services, general preventive services and health education, family planning services, laboratory and radiology services, pharmacy, prescriptions, dental services, vision services, medical supplies and equipment, transportation services.

For more information, refer to the Provider Manual for the Primary Care Network, available through the Medicaid agency.

14 DEFINITIONS

Following is a list of definitions relevant to the administration, policies and procedures of Utah's Medicaid Program:

Abuse: Refer to 'Provider Abuse.'
Assigned Claim: a claim for which the provider accepts the Medicare assignment of payment.
Audit Settlement: An agreement to resolve a civil financial Medicaid overpayment dispute when criminal charges are not currently filed.
Carve-out services: Services not included in the Medicaid contract with an individual managed care plan.
Child Health Evaluation and Care or **"CHEC":** The name used in Utah for the EPSDT program. This program is designed to bring comprehensive health care to individuals from birth to 21 years of age who are eligible for Medical Assistance.
Client: a person who applies for Medicaid and may be eligible. "Client" is used interchangeably with "recipient" when the person is eligible for the Utah Medicaid Program. Refer also to "Recipient".
Clinical Laboratory Improvement Amendments (CLIA): The federal Centers for Medicare & Medicaid Services (CMS) program which limits reimbursement for laboratory services based on the equipment and capability of the physician or laboratory to provide an appropriate, competent level of laboratory service.
Code of Federal Regulations (CFR): The publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid program. Federal rules promulgated by the Centers for Medicare & Medicaid Services (CMS) place requirements upon the state Medicaid agency, Medicaid providers, and recipients.
Covered Medicaid Service: Service available to an eligible Medicaid client within the constraints of the Utah Medicaid Program and criteria for approval of service.
Criminal Subpoena: An order signed by a judge obtained pursuant to a pending criminal investigation filed with the court as required by Utah Code § 77-22-2, which requests the named witnesses testimony or documents possessed by the person upon whom the subpoena is served (Subpoena Duces Tecum). A criminal subpoena is not a search warrant and does not provide authority for the serving office to enter a premise or inspect or seize property or persons.
Current Procedural Terminology Manual (CPT): The manual published by the American Medical Association that provides a systematic listing and coding of procedures and services performed by physicians and simplifies the reporting of services to third part payors.
Diagnosis Related Group (DRG): The system established to recognize and reimburse for the resources used to treat a client with a specific diagnosis or medical need. The is weight, average length of stay (ALOS), and outlier threshold days are extracted from Utah Medicaid paid claims history files or from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS).
Division of Health Care Financing: the organizational division in the Utah Department of Health which administers the Medicaid program in Utah.
Early Periodic Screening Diagnosis and Treatment or "**EPSDT":** Refer to 'Child Health Evaluation and Care'.
Enrolled Provider: A licensed practitioner of the healing arts or an entity providing approved Medicaid services to patients under a provider agreement with the Department.
Explanation of Benefits or **"E.O.B":** the form sent by a liable third party to a provider to explain whether a claim is paid and the amount paid or denied and the reason denied.
Explanation of Medicare Benefits or **"E.O.M.B":** the form received by the provider from Medicare to explain whether a claim is paid, the amount paid, or denied and the reason denied.
Federal Financial Participation or **"FFP":** the amount the federal government contributes to provider reimbursement for Medicaid or other medical services.
Federal Poverty Level (FPL): The poverty guidelines are a simplification of the poverty thresholds for use in determining financial eligibility for certain federal programs. The guidelines are issued each year in the Federal Register by the Department of Health and Human Services (HHS). The Federal Poverty Level is available on the Internet at http://aspe.hhs.gov/poverty/poverty.htm

Fee for Service: Services covered directly by Medicaid and not by a managed care plan. Reimbursement is an established amount of money paid to a provider in exchange for a specifically defined and coded service provided to a Medicaid client.

Fee-for-Service Medicaid client: A client who (1) is not enrolled in a managed care plan, such as a health maintenance organization (HMO); or (2) is enrolled in a managed care plan, but the service that is needed is covered by Medicaid, not by the plan.

Fraud: Refer to 'Medicaid Fraud'.

Healthcare Common Procedure Coding System: The system mandated by the Centers for Medicare & Medicaid Services (CMS) to code procedures and services. This system incorporates the CPT Manual for physicians and individually developed service codes and definitions for non-physician providers. The system may also include state only "Y" codes.

Health Maintenance Organization or **"HMO":** a managed care plan offering coverage for medical care which *may* include mental health, pharmacy and/or dental services.

Intermediary: an entity which contracts with Centers for Medicare & Medicaid Services (CMS) to determine and make Medicare payments for Part A or Part B benefits payable on a cost basis and to perform other related functions.

International Classification of Diseases or **"ICD":** the source for coding the diagnosis for which a patient is being treated.

Investigation: An official inquiry conducted by law enforcement officers of the Utah Department of Public Safety's Medicaid Fraud Unit, to prove or disprove evidence of criminal conduct. An investigation may begin by auditing provider records.

Medicaid: the medical assistance program authorized under Title XIX of the Social Security Act.

Medicaid Agency: the Utah Department of Health, Division of Health Care Financing.

Medicaid Audit: A civil or administrative process of reviewing Medicaid provider records to ensure accurate billing and payment for Medicaid claims.

Medicaid Fraud: Knowingly, recklessly, or intentionally presenting false information to the Medicaid agency with the intent to receive some unauthorized Medicaid benefit for any person or entity. Refer to Utah Code Ann. §§ 26-20-1, et seq.; Utah Administrative Rules, R414-22; and 42 C.F.R. § 455.2. Medicaid fraud violations may also be brought under more general state and federal theft and fraud statutes.

Medicaid Fraud Control Unit (MFCU): The official state Medicaid fraud control unit in the Department of Public Safety, certified by the federal government, to investigate and prosecute complaints of abuse and neglect of patients, and Medicaid fraud under state laws as required by 42 CFR §§ 1007.7 through 1007.13. The MFCU has state-wide prosecutorial authority.

Medicaid Information Bulletins: An official, periodic publication of the Division of Health Care financing to update the Utah Medicaid Provider Manual or issue information to Medicaid providers.

Medicaid Provider Agreement: A signed contract between a provider and the Utah Medicaid program by which the provider agrees to abide by all state and federal law related to the Medicaid Program, including providing medical and billing records for the purposes of conducting Medicaid and MFCU audits to determine fraud or abuse of the Medicaid program. The provider also agrees to abide by any subsequent amendments to the Agreement published in the Medicaid Information Bulletin. This agreement, together with the recipient's Medicaid application, authorizes the release of Medicaid records for Medicaid and MFCU auditing purposes.

Medical Necessity: A service is "medically necessary" if it is (1) reasonable calculated to prevent, diagnose, or cure conditions in the client that endanger life, cause suffering or pain, cause physical deformity or malfunction, or threaten to cause a handicap; and (2) there is no other equally effective course of treatment available or suitable for the client requesting the service which is more conservative or substantially less costly.

Medicare: the national health insurance program for aged and disabled persons under Title XVIII of the Social Security Act. Part A includes hospital and nursing home services. Part B pays professional fees, such as physicians, physical therapy, etc.

Overpayment: Refer to 'Provider Overpayment'.

Patient: an individual awaiting or receiving professional services directed by a licensed practitioner of the healing arts.
Physician: A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the state.
Plea Agreement: An agreement made between a prosecutor to resolve pending criminal charges against a Medicaid provider.
Prepaid Mental Health Plan or **"PMHP":** a managed care plan offering coverage for mental health care services.
Prior Authorization or **"PA":** required approval obtained by a health care provider from Medicaid (the Division of Health Care Financing, Department of Health) before service is rendered.
Provider: An entity or licensed practitioner of the healing arts furnishing medical, mental health, dental or pharmacy services.
Provider Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices resulting in unnecessary Medicaid costs. Reimbursement for services that are not medically necessary, fail to meet professionally recognized standards of care, or any practice that results in increased costs to Medicaid are also considered abuse. Criminal intent need not be alleged nor proved to establish abuse. Refer to 42 C.F.R. § 455.2.
Provider Agreement: Refer to 'Medicaid Provider Agreement'.
Provider Overpayment: An overpayment occurs when a Medicaid provider receives more Medicaid reimbursement than the provider is entitled, regardless what party is at fault.
Recipient: a person who is eligible for the Utah Medicaid Program and eligible to receive covered Medicaid services from an enrolled Medicaid provider.
Reimbursement: an established amount of money paid to a provider in exchange for a specifically defined and coded service provided to a Medicaid client.
Remittance Statement: the explanation from Medicaid as to claims which have been paid, denied or are in process.
Search Warrant: An order signed by a judge and served by a law enforcement officer, which identifies a specific location, items, or person to be searched based upon a judicial finding that probable cause exists to believe that the property or evidence was unlawfully acquired or possessed, used to commit or conceal the commission of a crime, or is evidence of illegal conduct. Refer to Utah Code §§ 77-23-201 and -202. Search warrants are also governed by the Fourth Amendment of the United States Constitution and article I, section 14 of the Utah Constitution.
Services: The types of medical assistance specified in Sections 1905(a)(1) through (25) of the Social Security Act and interpreted in 42 CFR 440 [October 1, 1996, edition].
Single State Agency: The agency which administers the Medicaid program in the State of Utah is the Utah Department of Health, Division of Health Care Financing.
Third Party Liability or **"TPL":** the responsibility of an individual, entity, or program which is or may be liable to pay all or part of the medical cost of injury, disease, or disability of a patient.
Title XIX: the Medicaid Program authorized by the Federal Social Security Act.
Utah Department of Health: the Single State Agency designated to administer or supervise the administration of the Medicaid Program under Title XIX of the federal Social Security Act. All references to "the Medicaid agency" mean the Department of Health. Reference: Utah Code Annotated §26-18-2.1 (1953, as amended) and Utah Administrative Code, Rule R414-1-2.
Utah Health Information Network or **"UHIN":** (1) a coalition of insurers, providers, the Utah Medical Association, the Utah Hospital Association, and State Government which developed an electronic data exchange to centralize transactions for providers and payers, including Medicaid. (2) the electronic data exchange, also referred to as UHIN or the UHIN network.
Wasatch Front: Weber, Davis, Salt Lake, and Utah counties
"Y" codes: Codes used only by the State to identify procedures and services, similarly to the Healthcare Common Procedure Coding System mandated by the Centers for Medicare & Medicaid Services.

14 - 1 Acronyms

Following is a list of acronyms commonly used in the administration, policies or procedures of Utah's Medicaid Program.

AFDC	Aid to Families with Dependent Children
ALOS	Average length of stay
CFR	Code of Federal Regulations
CHEC	Child Health Evaluation and Care
CHIP	Child Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services [formerly Health Care Financing Administration]
CPT	Current Procedural Terminology Manual
DFCS	Division of Child and Family Services
DHCF	Division of Health Care Financing
DHS	Department of Human Services
DOH	Department of Health
DRG	Diagnosis Related Group
DUR	Drug Utilization Review
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early Periodic Screening Diagnosis and Treatment
FDA	Food and Drug Administration
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FR	Federal Register
GRAMA	Government Records Access and Management Act
HCFA	Health Care Financing Administration (Federal) [Name changed to Centers for Medicare & Medicaid Services in June 2001]
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HHS	Department of Health and Human Services (Federal)
HIPPA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HPR	Health Program Representative
ICF	Intermediate Care Facility
IPA	Independent Practice Association
MFCU	Medicaid Fraud Control Unit
MFU	Medicaid Fraud Unit, now the MFCU
MM/EIS	Medicaid Management/Eligibility Information System (in development)
MMIS	Medicaid Management Information System
NCPDP	National Council of Prescription Drug Programs
OBRA	Omnibus Budget Reconciliation Act

ORS	Office of Recovery Services
ORSIS	Office of Recovery Services Information System
ORS	Office of Recovery Services
ORSIS	Office of Recovery Services Information System
PACMIS	Public Assistance Case Management Information System
PCP	Primary Care Physician
PCN	Primary Care Network
PMHP	Prepaid Mental Health Plan
POS	Point of Sale
PPO	Preferred Provider Organization
PRO	Peer Review Organization
QMB	Qualified Medicare Beneficiary
RBRVS	Resource-Based Relative Value Scale
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TPL	Third Party Liability
UHIN	Utah Health Information Network
UMA	Utah Medical Association
UMAP	Utah Medical Assistance Program
UHCA	Utah Health Care Association
UHA	Utah Hospital Association
WIC	Special Supplemental Food Program for Women, Infants, and Children

SECTION I: INDEX

Notes:
- Acronyms are listed separately on the preceding page. Acronyms are not included in the index.
- In the electronic version of SECTION 1 on the Internet (http://health.utah.gov/medicaid/pdfs/SECTION1.pdf), use the Adobe Acrobat FIND function to locate a keyword of interest. The icon on the toolbar is binoculars.
- Where there are multiple page numbers indexed to a keyword, the page number(s) in boldface type indicate a chapter heading on that keyword